OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT

Rulemaking File

Related to the California Health and Safety Code, Sections 128736 and 128737, which mandate the online transmission of Emergency Care Data Records (ED) and Ambulatory Surgery Data Records (AS) via the MIRCal system, the establishment of data elements for the Emergency Care Data Records (ED) and the Ambulatory Surgery Data Records (AS) with definitions based on the 837 Health Care Service Data Reporting Guide (HCSDRG) National Standard, and the establishment of specified due dates for ED and AS data reports.

Item 14

Written Comments and Responses

December 2004

OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT

Written Comments

The proposed regulation package was e-mailed to all non-federal licensed acute care hospitals in California, hospital industry organizations and other interested parties. OSHPD allowed a 45-day comment period for all parties interested in submitting written comments. No public hearings were requested or held regarding the proposed changes. OSHPD received twenty-four comments during the public comment period.

All of the e-mails concerning public comments are included under this item.

None of the questions/comments necessitated a modification to the regulations as originally proposed.

December 2004

Comment:

Date: October 4, 2004

From: Paul Hsu, MPH
Staff Research Associate
UCLA School of Public Health
Southern California Injury Prevention Research Center

To: Candace L. Diamond
Manager
Office of Statewide Health Planning and Development
Patient Discharge Data Section
818 K Street, Room 100
Sacramento, CA 95814

Re: public comment period on amendments and additions to Article 8 (implementing the mandated collection and transmission of Emergency Care and Ambulatory Surgery data through MIRCal)

As a researcher at the Injury Center and as a current doctoral student in epidemiology, I believe that the proposed guidelines will result in a data set that will be a useful and important step in understanding the health profile of those who receive emergency care and/or ambulatory surgery care in California. This information will supplement and enhance the already valuable hospital discharge data set. While recognizing the limited resources of the state, any additional variables (such as Glasgow Coma Score or extent of prehospital care received) that might capture the status of the incoming patient would also be valuable. In any case, the proposed regulations are a substantial step in keeping California at the forefront of health data standardization and accessibility.

Sincerely,

Paul Hsu

Response:

Thank you for your interest in of our proposed regulations. OSHPD is pleased to learn that you believe that the data set will be a useful and important step in understanding the health profile of those who receive emergency care and ambulatory surgery care in California.

OSHPD joins you in the belief that the currently proposed regulations, designed to implement the collection of the very basic and limited data set required by Sections 128736 and 128737 of (Title 22, Division 7, Chapter 10, Health Facility Data, Article 8, ~~Discharge~~ Patient Data Reporting Requirements) the California Health and Safety will constitute a substantial step toward keeping California at the forefront of health data standardization and accessibility. Thank you for your support. It is always encouraging to hear from potential data users and be able to share the news of the potential data use with data providers.

There is a possibility, based on Section 128738, that additional data elements may be added to the ED data set at a later time however that possibility is outside the scope of the currently proposed regulations and therefore cannot be addressed at this time.

Thank you for taking the time to respond to our proposed regulations. We appreciate your time and effort and hope that you will be able to use the basic ED and AS data and that you will continue to make us aware of your additional data element needs.

Comment:

Thank you for providing the California Asthma Partners (CAP) with an opportunity to comment on OSHPD's expansion of the MIRCal project to include data from Emergency and Ambulatory Surgery Departments across California. CAP is a statewide partnership of several hundred non-governmental organizations, agencies, institutions, coalitions, and collaboratives working to implement the *Strategic Plan for Asthma in California*. We submit these recommendations for increased data collection and reporting on behalf of the CAP Steering Committee.

Healthy People 2010: Objectives for Improving Health established a national goal to reduce hospital emergency department visits for asthma. Currently, there are no systems in place to measure the degree to which this goal is being met in California. We are excited that OSHPD's Collection of Emergency Department (ED) data will allow us to accurately assess ED visits for asthma and our progress toward meeting the Healthy People 2010 goal. Based on national rates, we can estimate that California's EDs see at least 250,000 people for asthma related treatment each year.

CAP urges you to consider collecting additional data elements, each of which is critical for providing a more comprehensive picture of patients who visit the ED, contributory risk factors, and the patterns of care that patients receive. Not only will these data enhance greater insights to California's health care system, but analysis of these data can result in more strategically targeted prevention programs. The recommended data elements are:

1. Address of the patient
2. Medications prescribed during the ED visit and for follow-up care
3. Time of day the patient arrived in the ED
4. Smoking status of the patient
5. How the patient arrived at the ED

Anticipated use of each data element is described below.

Address of the patient. This measure will provide an opportunity for more thorough analysis of environmental (both physical and social) exposure and its relationship to disease, since zip code level data is not specific enough. Many people with asthma are adversely affected by environmental triggers (e.g. engine exhaust, pesticide spraying, etc.); knowing a patient's address will help to correlate environmental exposures, such as proximity to freeways and oil refineries, with the incidences of ED visits. It will also tell us which communities, also not necessarily defined by zip code, have better controlled asthma. CAP recognizes that it is important to protect patient confidentiality and maintain compliance with HIPAA regulations, and understands that only certain organizations, such as the California Department of Health Services, would have access to this information. The Environmental Health Investigations Branch,

within the California Department of Health Services, is willing to assist CAP by evaluating this confidential data.

Medications prescribed during the ED visit and for follow-up care. Medications prescribed can serve as one indicator of the quality of acute care. More importantly, this element in combination with planned follow-up can help to evaluate whether an approach to *transitional care* is being initiated. As you may know, the National Heart, Lung, and Blood Institute (NHLBI), as well as the Global Iniative for Asthma (GINA), established treatment guidelines to ensure the highest quality care for asthma. HEDIS, the Health Plan Employer Data and Information Set, is a set of standardized performance measures designed to help people make decisions about care for significant public health issues such as cancer, heart disease, smoking, asthma and diabetes. For asthma, the HEDIS® has created the Use of Appropriate Medications for People with Asthma measure to evaluate whether health plan members suffering from persistent asthma are being prescribed medications deemed acceptable by NHLBI/GINA. By collecting medication data, this measure could also be used in the ED to demonstrate how well treatment guidelines are applied.

Time of day the patient arrived in the ED. This information could be linked to data on air pollution, revealing important links between "bad air" events and asthma exacerbations. This will strengthen the analysis that is supported by patient address (described above) and may help to orient environmental and preventive interventions.

Smoking status of the patient. This measure will help to determine the associations between health problems in the ED and smoking, thereby enabling more effective outreach campaigns to minimize smoking. Not only does smoking exacerbate asthma symptoms, but it is known to increase the severity of symptoms for several leading public health issues, including cancer, heart disease, and diabetes.

How the patient arrived at the ED—whether s/he walked-in or arrived via ambulance. This data element will help to assess the severity of acute asthma exacerbations. More importantly, it will help to better define patterns of healthcare access across California in association with other demographic and clinical parameters. The ED often serves as a primary care clinic for under- and un-insured patients. Among people seeking treatment for asthma, those who arrive via ambulance are more likely to be experiencing a severe asthma attack. Walk-in patients, on the other hand, may view the ED as a place to receive non-emergency services.

ED visits by people with asthma can be prevented with improved asthma management. It is our hope that the additional ED data provided by OSHPD will enable CAP and its many asthma partners to better assess the burden of asthma in California. Each of the data elements we propose is critical to improved

targeting of educational, treatment, management, and policy-based interventions for asthma and other conditions seen in the ED.

We will be following this process of data collection closely and look forward to continued involvement as you move forward. If you would like to discuss our recommendations further, please contact Jen Bolcoa. Thank you for your attention.

Lynn Devine
CAP Co-Chair
American Lung Association of California

Craig Jones, MD
CAP Co-Chair
Los Angeles County and University of Southern California Medical Center

Response:

Thank you for your interest in our proposed regulations. OSHPD is pleased to learn that California Asthma Partners (CAP), a statewide partnership of several hundred non-governmental organizations, agencies, institutions, coalitions, and collaboratives, is interested in using the Emergency Department (ED) data to accurately assess ED visits for asthma and assess progress toward meeting the Healthy People 2010 goal. It is always encouraging to hear from potential data users and be able to share the news of the potential data use with data providers.

The currently proposed regulations (Title 22, Division 7, Chapter 10, Health Facility Data, Article 8, ~~Discharge~~ Patient Data Reporting Requirements) are designed to implement the collection of the very basic and limited data set required by Sections 128736 and 128737 of the California Health and Safety Code. Based on Section 128738 OSHPD may exchange data elements or add up to a net of 15 data elements to each data set over any five-year period. Additional data elements contained in the uniform claims transaction set or uniform billing form required by the Health Insurance Portability and Accountability Act (HIPAA) may also be added to the ED data set at a later time. That possibility is outside the scope of the currently proposed regulations and, therefore, cannot be addressed at this time.

Thank you for taking the time to respond to our proposed regulations. We appreciate your time and effort and hope that you will be able to use the basic ED data and that you will continue to make us aware of your additional data element needs.

Comment:

It would be very useful to be able to identify the subset of ED visits that are designated as Trauma visits. I don't see this as a separate variable, and am not sure if there's another way to identify these patients. Given the precarious state of the Trauma system in Los Angeles County, I can envision many uses for being able to analyze this population. Irene Dyer, MS, MPH Acting Director, LAC DHS Office of Planning, Data Quality and Analysis

Response:

Your observation that there is not a separate variable to identify trauma is correct. It is not possible to reliably subset the Trauma visits from ED visits at the same facility as reported to OSHPD. Diagnoses and E-codes reported are available in the proposed data set.

The currently proposed regulations (Title 22, Division 7, Chapter 10, Health Facility Data, Article 8, ~~Discharge~~ Patient Data Reporting Requirements) are designed to implement the collection of the very basic and limited data set required by Sections 128736 and 128737 of the California Health and Safety Code. There is a possibility, based on Section 128738, that additional data elements may be added to the ED data set at a later time. That possibility is outside the scope of the currently proposed regulations and therefore cannot be addressed at this time.

Thank you for taking the time to respond to our proposed regulations. We appreciate your time and effort and hope that our response will address your concerns.

Comments:

LOMA LINDA UNIVERSITY MEDICAL CENTER

Memorandum

To: Candace L. Diamond
From: Compliance Department
Date: October 4, 2004
Subject: Response

The purpose of this letter is to comment on OSHPD's proposed changes to Title 22 to support the implementation of the mandated collection and transmission of Emergency Care and Ambulatory Surgery data.
It is important to note that our hospital fully supports the submission of data required by Health and Safety Code Sections 128736 and 128737. Additionally, we acknowledge that many of the required data elements for emergency care and ambulatory surgery care are the same as the required inpatient elements; however, we are concerned that for several of the required data elements, OSHPD is proposing that hospitals submit emergency care and ambulatory surgery data in a format that differs from what is currently required for submission of inpatient data.
The format differences for data submission on the items listed in the grid below will pose a significant challenge to our hospital.

Data Element	Inpatient	Emergency/Ambulatory Surgery
Data of Birth – data sequencing	mmddccyy	ccyymmdd
Sex	Numeric	Alpha
Zip Code	Alphanumeric	Numeric
Race	Numeric	Alphanumeric
Ethnicity	Numeric	Alphanumeric
Admission Date – data sequencing	mmddccyy	ccyymmdd
Disposition of Patient – both numeric but different descriptions for same code.		
Expected Source of Pymt.	Numeric	Alphanumeric

The formatting differences in reporting of the above data elements will require extensive training for the staff that are collecting and abstracting this data. Additionally, the reporting differences will cause our facility to maintain separate databases to meet the inpatient and outpatient requirements, thus requiring significant changes to our current system set up. These different databases will also complicate our ability to run reports that include both inpatient and outpatient data. We acknowledge that the new reporting format utilizes National Standards and would recommend that if these standards are to be utilized, they be implemented for both inpatient and outpatient at the same time.
In summary, we support the efforts of OSHPD in working to collect the data required by the Health and Safety Code; however, we strongly recommend that one reporting format be utilized for both inpatient and outpatient data.

Response:

Thank you for your comments regarding OSHPD's proposed changes to Patient Data Reporting Requirements (Title 22, Division 7, Chapter 10 - Health Facility Data, Article 8). Thank you also for your support of the concept that using a national standard is a generally beneficial concept and for supporting the submission of data required by Health and Safety Code Sections 128736 and 128737. OSHPD greatly appreciates your comments.

The currently proposed regulations (Title 22, Division 7, Chapter 10, Health Facility Data, Article 8, ~~Discharge~~ Patient Data Reporting Requirements) are designed to implement the collection of the very basic and limited data set required by Sections 128736 and 128737 of the California Health and Safety Code using a national standard data set. The proposed regulations were written to implement, interpret, and make specific the provisions of Sections 128736 and 126737. After considering several national standard data sets OSHPD chose the *837 Health Care Service Data Reporting Guide (HCSDRG).* OSHPD hoped to facilitate addition of ED and AS reporting by using the ANSI X12 national standard 837 HCSDRG because it is compatible with the data content of other 837 Health Care Claim transaction set standards that are currently used by facilities to submit claims. Data extraction from an 837 Claim format to the 837 HCSDRG format may be used to provide data content for the ED and AS records.

Other factors that influenced OSHPD's decision to use the 837 HCSDRG reporting guide include HIPAA compatibility and the fact that the reporting guide also includes other data elements that OSHPD is mandated to collect. For example, while diagnosis and procedure codes are in the claim standard the "race and ethnicity" are data elements missing from the 837 institutional claims standard.

OSHPD has been in the data collecting business for several decades and has a vested interest in the highest quality data. We have confidence that the very competent staff at Loma Linda will overcome the challenges imposed by these requirements and will continue to provide quality data. Adjusting to any new reporting requirement involves staff training and an adjustment period. In response to these concerns OSHPD will make the expanded MIRCal system available for submission of data on a voluntary basis for the October to December 2004 reporting period. This is a great opportunity for Loma Linda to "try the system out" and begin the staff learning curve. The online Computer Based Training and annual seminars may also help ease the transition to reporting ED and AS data. OSHPD MIRCal analysts will be available for assistance from 8 a.m. to 5 p.m., Monday through Friday, except for Official State Holidays. There will be no penalties for not reporting fourth quarter data. Mandatory reporting will begin with the January 1, 2005, through March 31, 2005, data that will be due May 15th, 2005.

Thank you for taking the time to respond to our proposed regulations. We appreciate your time and effort and hope that our response addresses your concerns.

Comment:

Date
September 30, 2004

To
Candice L. Diamond
Office of Statewide Health Planning and Development

From
Rosanne Lippert, MHS, RHIA, for Catholic Healthcare West
Health Information Management Operations Council

Subject
PUBLIC COMMENT – Proposed OSHPD Data Reporting for ED and Outpatient Surgery

In reviewing the proposed regulations for reporting of Emergency and Ambulatory Surgery data to OSHPD there are several issues that inhibit a hospital's ability to comply with the requirements. The CHW HIM Operations Council, on behalf of our 38 CHW facilities, would like to submit our concerns to OSHPD during the public comment period. The issues identified thus far include:

#1. OSHPD's definition of ambulatory surgery includes only those outpatient procedures performed in an operating room, ambulatory surgery room, endoscopy unit or cardiac cath lab of a hospital. This excludes a number of outpatient procedures which are performed in other areas of the hospital (i.e. outpatient oncology, some imaging and nuclear medicine procedures, Breast Center biopsies, etc.). These procedures include lung biopsies, liver biopsies, thyroid biopsies, thoracentesis, paracentesis, arteriograms, stereotactic breast biopsies, transfusions, etc. which are invasive, carry risk and may require some level of anesthesia/sedation (based on California Code of Regulations Section 97263 it seems that these procedures should be included in the data reporting). Many hospital information systems combine all ambulatory/same day procedures into a single category/patient type to differentiate them from inpatient, ER or SNF encounters. Most hospital computer systems collecting OSHPD reportable data do not have the ability to sort out ambulatory visit data based on the location in the hospital where the procedure was performed. OSHPD has indicated that they believe that hospitals may be able to extract this data from the UB92 computer files rather than the traditional encoder/abstracting systems. The CHW I.S. Dept. has indicated that it would be significantly more complex and costly to produce such a report from this file rather than from the abstracting system. Either of these options (re-programming the computerized abstract database or creating a new program from the UB92 database) places a significant unanticipated burden on the facilities in terms of cost and resources.

#2. OSHPD does not want data for procedures that were cancelled before the procedure began. This is problematic due to the fact the modifiers are utilized to indicate that surgery was cancelled before or after anesthesia and OSHPD does not

want any modifiers reported, just the CPT codes. Thus, a procedure reported without the modifier would erroneously indicate that the procedure was completed. The absence of modifiers is a significant issue in terms of the accuracy and usefulness of the users of OSHPD data.

#3. OSHPD has also requested that data be submitted on patients who come in for treatment in the ED or Ambulatory Surgery setting and then are later admitted for observation. Information is not available to discern which patients came in as Observation and which ones were changed to Observation after coming into the ED or Ambulatory Surgery areas.

#4: OSHPD requires reporting of procedures performed in the cardiac cath labs. These are "out of scope" procedures which many facilities do not now code for CPT, such as cardioversion or cardiac catheterization. Since these out of scope codes are usually embedded in the CDM, getting this information into an OSHPD file will be problematic for many hospital computer systems. If coding staff are required to begin entering these codes, this is a significant increase in labor.

#5. Although OSHPD requires the reporting of all ED visits, it has not been clearly defined whether this includes patients who are dead on arrival, left without being seen, left against medical advice, etc. OSHPD seems to indicate that they are only interested in data for a patient who has been seen by a physician. If so, distinguishing between these types of patients for reporting purposes would also be problematic.

#6. The reporting requirements for several of the ED and Ambulatory Surgery data elements differ significantly from the inpatient requirements. Understanding that the changes to the codes for race, sex, date of birth, zip code, etc. for ED/ AS will move our state towards compliance with the national standards, the inconsistencies between the inpatient and outpatient data requirements cause significant programmatic / mapping issues from an I.S. perspective. Our computer systems gather patient information from both inpatient and outpatient visits across the continuum of care and should contain a single value for data elements throughout our database.

SUMMARY: While CHW recognizes the State's goals to collect accurate patient visit information for the improvement of quality care, there are significant issues related to the collection and reporting of the Ambulatory Surgery and ED data by facilities to OSHPD which remain unresolved. Unless these issues are satisfactorily addressed, the data submitted to OSHPD will be inconsistent across the state, making meaningful comparison among facilities across California impossible. We believe that additional research and collaboration with California facilities is necessary before the implementation of the proposed regulations.

Response:

Thank you for your comments regarding OSHPD's proposed changes to Patient Data Reporting Requirements (Title 22, Division 7, Chapter 10 - Health Facility Data, Article 8).

The definition of ambulatory surgery in the proposed regulatory text is based on the text of the California Health and Safety Code, Title 22, Section 128700, which states that "Ambulatory surgery procedures" mean those procedures performed on an outpatient basis in the general operating rooms, ambulatory surgery rooms, endoscopy units, or cardiac catheterization laboratories of a hospital or a freestanding ambulatory surgery clinic." OSHPD cannot propose regulations that enlarge the statute and therefore cannot mandate data collection from any areas other than those listed in the law. This has the effect that a number of outpatient procedures performed in other areas of the hospital are not mandated for collection.

Data extraction from other (electronic claims) records currently collected by your hospital may be used to provide data content for the ED and AS records.

California Code of Regulations Section 97263 requires that "All significant procedures are to be reported. A significant procedure is one that is surgical in nature, or carries a procedural risk, or carries an anesthetic risk. Procedures shall be coded according to the Current Procedural Terminology, Fourth Edition (CPT-4)." There are two criteria that are to be applied when deciding what to report to OSHPD. The first criterion is "If the procedure was done on an outpatient basis in the qualified areas specified in the law, then report the record to OSHPD." The second criterion is to determine which of those procedures also meet a risk criterion. Both criteria should be met for OSHPD reporting.

OSHPD is aware of the variety of computer systems, and variety in hardware and software across health care facilities within the State. A facility may have several computer systems with varying degrees of compatibility. This is why OSHPD is proposing to expand the use of its MIRCal system to collect data rather than proposing software and hardware purchases for each facility. OSHPD will accept data from any source that meets the MIRCal format and specification requirements. Mapping from claims forms, (chargemaster) billing information, medical records, admissions data or any other pre-entered data-source may be possible and may reduce repeated key or manual entry of data.

The issue of outlay was a relevant factor in OSHPD decision-making and was one of the factors that led to the selection of the 837 format that is already used by any facility that is filing electronic claims. OSHPD anticipated that the length of time between the passage of the law and the proposed regulations would give facilities time to meet HIPAA compliance. Reporting has been changed to be on a voluntary basis for the October to December 2004 reporting period. OSHPD hopes that the additional time before reporting begins will be of benefit to your facilities as they determine how best to meet the ED and AS data collection requirements.

When providing OSHPD data for procedures that were cancelled before the procedure began, the appropriate V64 code should be reported as one of the other diagnoses using ICD-9-CM codes. If a procedure is begun but cannot be completed, report the record to OSHPD showing the CPT procedure code. Because OSHPD is not collecting modifiers, we are requesting that the V64 as an Other Diagnosis be used to explain the reason for the incomplete procedure. This technical issue will be covered in greater depth in a future issue of the *Quick Notes* newsletter.

OSHPD has learned from facilities that modifiers are not used consistently for the same procedures due to inconsistencies between different payers' instructions leading to conflicting data from inconsistent uses of modifiers. CMS, AMA, AHA, and the CHA Payer Committee are all attempting to determine ways to make sure the modifiers are being applied consistently, regardless of payer requirements. Note that the 3M APG (not APC) grouper will similarly not accept modifiers.

OSHPD requires that data be submitted on patients who come in for treatment in the ED or AS setting and then are later admitted. OSHPD also requires reporting of procedures performed in the cardiac catheterization laboratories. This is another area where the additional time before mandatory reporting begins (January 1, 2005 to March 31, 2005 data are due on May 15th, 2005) will be of benefit to your facilities as they determine how best to meet the ED and AS data collection requirements.

OSHPD is mandated to collect ED and AS encounter data that is defined in 97212 (j) as a face-to-face contact between an outpatient and a provider. Section 97212 (t) of the proposed regulations defines a provider as the person who has primary responsibility for assessing and treating the condition of the patient at a given contact and exercises independent judgment in the care of the patient. This would include a practitioner licensed as a Medical Doctor (M.D.), a Doctor of Osteopathy (D.O.), a Doctor of Dental Surgery (D.D.S.), or a Doctor of Podiatric Medicine (D.P.M.). If the patient was not seen by a provider who meets the given definition then the record would not need to be reported to OSHPD. This excludes persons who are dead on arrival and persons who leave without being seen. Patients who leave against medical advice should be reported if they meet the criteria stated above, and should not reported if they do not. Please refer to the definitions for encounter, outpatient and provider.

At the time that the MIRCal online transmission system was developed for discharge (inpatient) data the national standards were not established or implemented. Now, with the ED and AS (outpatient) expansion of MIRCal, national standards are established, implemented, and required for electronic transmission of claims. This enables OSHPD to design the expanded phase of MIRCal to be consistent with national standards. OSHPD's long-range plan is to migrate the inpatient data to the national standards data set also. This migration

will require Health and Human Services Agency and other state control agency approval for an information technology project, and the appropriation of adequate funds for system development, procurement and implementation. OSHPD is proposing the use of a national standard for ED and AS data and the concurrent use of OSHPD's long-established proprietary data set for inpatient data at this time.

The proposed regulations were written to implement, interpret, and make specific the provisions of SB 1973 as they have been written into Sections 128736 and 126737 of the California Health and Safety Code.

OSHPD researched a variety of national standards trying to assess which national standard would best meet the data collection required by statute and which would also cause least collection effort on the part of impacted facilities. It became clear OSHPD could not fulfill the mandate of SB 1973 by selecting a national standard that would replace our proprietary Discharge (Inpatient) Data set and that national data standards occasionally had different data definitions for similarly named data elements.

After considering several national standard data sets, OSHPD chose the *837 Health Care Service Data Reporting Guide (HCSDRG).* OSHPD hopes to facilitate addition of ED and AS reporting by using the ANSI X12 national standard 837 HCSDRG because it is compatible with the format of other 837 Health Care Claim transaction set standards that are currently used by facilities to submit electronic claims. OSHPD anticipates that this will enable the common interchange structure of data and lessen the burden of meeting the data reporting requirements. Extracting data from an 837 Claim format to the 837 HCSDRG format should be possible for most facilities.

Other factors that influenced OSHPD's decision to use the 837 HCSDRG include HIPAA compatibility and the fact that the reporting guide also includes other data elements that OSHPD is mandated to collect. For example, while diagnosis and procedure codes are in the claim standard the "race and ethnicity" are data elements missing from the national claims standards.

OSHPD is confident that Catholic Healthcare West will be able to develop ED and AS reporting solutions, based on the knowledge that CHW is thriving in a very competitive healthcare environment and has access to skilled programmers and staff experts in a number of healthcare information disciplines. OSHPD is not requiring the mandatory reporting of ED and AS data until May 15, 2005.

OSHPD anticipates, based on the issues that you raise, that there will be a "learning curve" as the new data is submitted. To ease the transition, please note that the expanded MIRCal system will available for submission of data, on a voluntary basis, for the October to December 2004 reporting period. This is an opportunity to "try the system out" and test the mapping of data from various in-

house systems. Facilities who voluntarily report will have immediate access to limited OSHPD staff resources and will also benefit from being able to initiate in-house staff learning in the least stressful environment. OSHPD MIRCal analysts will be available for assistance from 8 a.m. to 5 p.m., Monday through Friday, except for Official State Holidays.

Thank you for taking the time to respond to our proposed regulations related to the collection and reporting of Ambulatory Surgery and Emergency Department data. OSHPD has proposed the regulations that it feels most accurately implement, interpret, and make specific the provisions of SB 1973 (as they have been written into Sections 128736 and 126737 of the California Health and Safety Code) whilst being least burdensome to most facilities.

OSHPD hopes that the responses, and the understanding that regulations cannot enlarge or restrict a statute, nor can they make proposals that are inconsistent or in conflict with a statute, will allow CHW to continue to move forward with its efforts to meet the requirements imposed by SB 1973. We appreciate your time and effort and hope that our response will address your concerns.

Comments:

September 1, 2004

Candace L. Diamond, Manager
Medical Information Reporting for California
Office of Statewide Health, Planning and Development
818 K. Street, Room 100
Sacramento, CA 95814

RE: EMERGENCY CARE AND AMBULATORY SURGERY DATA SUBMISSION

Dear Ms. Diamond:

This letter is being written in response to the proposed regulatory action to require the collection and submission of Emergency Care and Ambulatory Surgery data to OSHPD via the MIRCal online transmission system. In analyzing our processes, we identified the following items as areas of concern.

1. **Variation in Data Elements for Inpatients versus Emergency Room and/or Ambulatory Surgery Patients.**
I would assume that the greatest number of Emergency Room patients will be reported by acute care facilities. Most hospitals that I am familiar with typically have a single registration and medical record abstracting application – regardless of patient types.

The variation in data elements requires additional data field choices, and/or additional training of staff and/or additional programming time to convert the information collected to the new format. Following are examples where this may be an issue:
Date of Birth-for inpatient data submission need to report month/day/year. For ER/AS on line submission it has to be year/month/day. Another program map to change this field format.
Zip Code – 99999 for Emergency Room and XXXXX for Inpatient
What do we do with the homeless patient seen in the Emergency room? For an inpatient, we would use the homeless code = ZZZZZ
If the homeless patient is in the Emergency room and we use 99999 but then the patient is admitted, we then are no longer accurately reporting the zip code for the inpatient admission or we have to take the extra staff time to double check zip code when the patient is admitted.
Race – For emergency room and ambulatory surgery patients it appears to be necessary to identify the race of Asian separately from a Pacific Islander. Is this not important on to know for inpatients?
Disposition of Patient-It is noted by OSHPD that all the disposition codes and descriptions are different. Since our system has one field to enter the

disposition, the person entering the information will have a lengthy pick list – which will probably increase the error rate.

It appears part of the goal for OSHPD is to report data elements based on the 837 Health Care Service Data Reporting Guide. I commend you for this effort to follow national guidelines. However, if it is so important to have these elements implemented in this manner now, why not update the inpatient element requirements first so that the data elements can be collected the same and not put the extra burden on the hospital to expand dictionary choices, develop system maps based on the patient service, train staff on additional multiple dictionary definitions, etc.

2. Medicare Billing Requirements: The Medicare 72 hour rule requires us to combine outpatient charges with inpatient charges if the outpatient visit occurs within 3 days of the visit. At our facility the charges are completely removed from the outpatient account and placed on the inpatient account. When these charges are moved the CPT codes are also moved. Therefore while we would report these patients, there will be no CPT codes (if they are chargemaster driven).

3. Service Date: We will need clarification on service date. For patients who are classified as ER or AS but their stay is extended overnight, the system assigns an admit date and discharge date. In this situation, should the "service date" equal the initial admit date or the discharge date?

4. Plan Code: Again, most hospitals utilize a single system to identify plan code for all patient services. In this situation it will require hospitals to maintain two different dictionaries – one for inpatient and one for outpatient.

5. ER Patients – left without treatment: In order to track patients for EMTALA purposes, we register all patients who present to our ER even though they may leave without being seen. In this case we actually assign ICD 9 code of V68.9 to the patient's record. Is the expectation to report these patients and if so, is this the correct code to use?

6. Ambulatory Surgery Definition: The ambulatory surgery definition is "procedures performed on an outpatient basis in the general operating rooms, ambulatory surgery rooms, endoscopy units or cardiac catheterization laboratories of a hospital or free standing ambulatory surgery clinic".

In our hospital this would exclude procedures such as bone marrow aspirations being performed in our outpatient cancer clinic or biopsies being performed in our radiology department or pathology department.

In addition, we have procedures such as angiography that can be performed in our cardiac cath lab or in our Radiology department. Based on the definition, we would only report those performed in the cardiac cath lab.

Rather than defining a particular unit or service, it may be more appropriate for OSHPD to require a specific range of CPT codes to be submitted for any type of outpatient service.

7. **Principal Procedure**: The title "Principal Procedure" may be misleading. Many of the CPT codes reported for outpatient services are not manually abstracted by the coding staff. The CPT codes are associated with the chargemaster. At our hospital, CPT codes will need to be reported from both the abstracting system and the chargemaster billing system. If there are CPT codes from both systems, is the very first chargemaster CPT considered the Principal Procedure or the very first CPT code entered by the coding staff? If all the CPT codes are derived from the chargemaster, there will be no sequence by priority or "principal".

Thank you for reviewing our concerns. I am sure that the collection of ER and AS data is important for state and health care agency planning, but is would certainly make it easier for most hospitals to have data definitions be in sync with one another, regardless of the patient service. Again we applaud the intent to move to the 837 reporting standards.

Sincerely,

Leslie Scarborough, RHIA
Director, Health Information Management
Hoag Memorial

Response:

Thank you for your comments regarding OSHPD's proposed changes to Patient Data Reporting Requirements (Title 22, Division 7, Chapter 10 - Health Facility Data, Article 8).

OSHPD is proposing concurrent use of its established data set for inpatient data and a national standard data set for Emergency Department (ED) and Ambulatory Surgery (AS) data. The reason that OSHPD is proposing concurrent use of OSHPD's long-established proprietary data set for inpatient data and a data set with some differences for Emergency Department (ED) and Ambulatory Surgery (AS) data lies in the legislation (SB1973, Maddy) that was passed in 1998 requiring the collection of Emergency Department and Ambulatory Surgery data. SB 1973 was incorporated into the California Health and Safety Code in Sections 128736 and 128737 which state that Emergency Department and Ambulatory Surgery data shall be reported to OSHPD using a national standard. The proposed regulations were written to implement, interpret, and make specific the provisions of Sections 128736 and 126737. OSHPD would like to migrate the inpatient data to the national standard data set at some time in the future.

After considering several national standard data sets OSHPD chose the *837 Health Care Service Data Reporting Guide (HCSDRG).* OSHPD hoped to facilitate addition of ED and AS reporting by using the ANSI X12 national standard 837 HCSDRG because it is compatible with the data content of other 837 Health Care Claim transaction set standards that are currently used by facilities to submit claims. Extracting from an 837 Claim format to the 837 HCSDRG format should resolve issues for submission to OSHPD.

Other factors that influenced OSHPD's decision to use the 837 HCSDRG include HIPAA compatibility and the fact that the reporting guide includes other data elements that OSHPD is mandated to collect. For example, while diagnosis and procedure codes are in the claim standard the "race and ethnicity" are data elements missing from the 837 institutional claims standard.

Any one facility may have several computer systems with varying degrees of compatibility. OSHPD, while unable to provide software or mapping solutions for all facilities, will accept data from any source that meets the MIRCal format and specification requirements. Mapping from claims forms, (chargemaster) billing information, medical records, admissions data or any other pre-entered data-source may be possible and may reduce repeated key or manual entry of data. Part of the reason behind using a national standard data set was to reduce multiple entry situations. Extracting from an 837 Claim format to the 837 HCSDRG format should resolve ED and AS data issues for submission to OSHPD.

Regarding the Medicare billing issue, please continue to report as you already do for inpatient data. Continuing the current practice complies with these proposed regulations.

The service date reported to OSHPD should be the 'start of care' date. It may be known as the "From Date" or "Begin Date" in billing.

The law, upon which the regulation is based, Health and Safety Code Section 128700, defines an encounter as a face-to-face contact between a patient and the provider who has primary responsibility for assessing and treating the condition of the patient at a given contact and exercises independent judgment in the care of the patient. The proposed regulations (Section 97212) define a provider as the person who has primary responsibility for assessing and treating the condition of the patient at a given contact and exercises independent judgment in the care of the patient. This would include a practitioner licensed as a Medical Doctor (M.D.), a Doctor of Osteopathy (D.O.), a Doctor of Dental Surgery (D.D.S.), or a Doctor of Podiatric Medicine (D.P.M). A patient who has not had a face-to-face encounter with a provider does not necessitate a record be reported to OSHPD as an ED encounter.

The ambulatory surgery definition (procedures performed on an outpatient basis in the general operating rooms, ambulatory surgery rooms, endoscopy units or cardiac catheterization laboratories of a hospital or free standing ambulatory surgery clinic) does exclude procedures performed in an outpatient cancer clinic, those performed in a radiology department or pathology department, or others performed in a Radiology department. OSHPD, limited by the text of the law, cannot propose regulations that are contrary to the language of the law.

OSHPD anticipates that there will be a “learning curve” as the new data are submitted. To ease the transition, the expanded MIRCal system will available for submission of data, on a voluntary basis, for the October to December 2004 reporting period. This is an opportunity to “try the system out” and test the mapping of data from various in-house systems. OSHPD MIRCal analysts will be available for assistance from 8 a.m. to 5 p.m., Monday through Friday, except for Official State Holidays.

Thank you for taking the time to respond to our proposed regulations. We appreciate your time and effort and hope that our response will address your concerns.

Comment:

>>> "Roy, Catherine R" <> 8/24/2004 4:01:50 PM >>>

Irene:
In reviewing the comparison of data elements for IP vs ED, there are fields which are in direct conflict with the IP data collection. These could possibly be resolved with the addition of conversion tables to our hospital systems, but this would be a major expense to each of our organizations as these requests would be fed back to our hospital system vendors. To further complicate matters, there are date fields which have also be transposed.

If you wish to incorporate these changes, would it not make sense to maintain a standard for reporting for any area of service (IP, ED, AS), and/or, have the conversion tables at the state level to allow for the changes you wish to implement thereby reducing the overall impact to the entire state?

Thank you for allowing our input.

Community Hospital of the Monterey Peninsula

Response:

Thank you for your comments regarding OSHPD's proposed changes to Patient Data Reporting Requirements (Title 22, Division 7, Chapter 10 - Health Facility Data, Article 8).

The reason that OSHPD is proposing concurrent use of the long-established proprietary data set for inpatient data and a different data set for Emergency Department (ED) and Ambulatory Surgery (AS) data lies in the legislation (SB1973, Maddy) that was passed in 1998 requiring the collection of Emergency Department and Ambulatory Surgery data. SB 1973 was incorporated into the California Health and Safety Code in Sections 128736 and 128737 which state that Emergency Department and Ambulatory Surgery data shall be reported to OSHPD using a National Standard. The proposed regulations were written to implement, interpret, and make specific the provisions of Sections 128736 and 126737. OSHPD would like to migrate the inpatient data to the national standard data set at some time in the future. This migration is not possible at this time and falls outside the scope of the currently proposed regulations.

After considering several national standard data sets OSHPD chose the *837 Health Care Service Data Reporting Guide (HCSDRG).* OSHPD hoped to facilitate addition of ED and AS reporting by using the ANSI X12 national standard 837 HCSDRG because it is compatible with the format of other 837 Health Care Claim transaction set standards that are currently used by facilities to electronically submit claims. Data extraction from other (electronic claims) records currently collected by your hospital may provide data content for the ED and AS records.

OSHPD anticipates that facilities will prove to be very capable of best determining how to meet the data standards given each facility's current practices and data capture software and data processing. An OSHPD conversion table might complicate reporting rather than simplifying it. OSHPD will accept data from any source that meets the MIRCal format and specification requirements. Mapping from claims forms, (chargemaster) billing information, medical records, admissions data or any other pre-entered data-source may be possible and may reduce repeated key or manual entry of data.

Thank you for taking the time to respond to our proposed regulations. We appreciate your time and effort and hope that our response will address your concerns.

Comments:

QuadraMed, Inc.
12110 Sunset Hills Rd., Suite 600
September 30, 2004

Candace L. Diamond, Manager
Medical Information Reporting for California
Office of Statewide Health, Planning and Development (OSHPD)
818 K. Street, Room 100
Sacramento, CA 95814

RE: EMERGENCY CARE AND AMBULATORY SURGERY DATA SUBMISSION

Dear Ms. Diamond:

This letter is being written in response to the proposed regulatory action to require the collection and submission of Emergency Care and Ambulatory Surgery data. As the Health Information System vendor for numerous hospitals in California, after analyzing the proposed requirements and having several conference calls with our clients in California, we have significant concerns about key aspects of the proposed requirements.

1. **Definition of Ambulatory Surgery**: The California Code of Regulations, Title 22, Division 7, Chapter 10, Article 8, Paragraph 97213, currently defines Ambulatory Surgery (AS) as "procedures performed on an outpatient basis in the general operating rooms, ambulatory surgery rooms, endoscopy units or cardiac catheterization laboratories of a hospital or free standing ambulatory surgery clinic." This definition appears to place more emphasis on the location where the procedure is performed rather than what procedures are performed. During the conference calls with our California hospital clients, it became very clear that certain ambulatory surgical procedures, such as biopsies, angiography studies, cardiac catheterizations, etc., are performed in various locations within the hospital. Not all these locations are currently defined within the regulation. However, simply expanding the definition of 'location' is not the solution either. In order to select the patient accounts to include in the reporting, a computer system must be able to identify a unique item or set of items on each patient account. During the conference calls with our clients, it also became clear that based on this current definition of 'ambulatory surgery', it will be impossible to establish these necessary unique data items. <u>The end result is that OSHPD will receive inconsistent data from the hospitals.</u> Rather than basing an AS definition on where the procedure is performed, it might be more

appropriate for OSHPD to identify either a range of CPT-4 codes or ICD-9-CM codes for identification purposes. From working with many other State's ambulatory surgery discharge data reporting requirements, we find almost all have clearly delineated a range of ICD-9-CM or CPT-4 codes that are considered 'procedures'. With this clear distinction, it becomes quite easy for a computer system to identify the applicable patient accounts that should be reported.

2. **Procedure Code Reporting for ED and AS Data**: The current proposed *ED and AS Format and Specifications* document indicates procedure codes are to be based on CPT-4 and there is a specific field for the 'Principal Procedure'. We have two concerns related to this requirement.
    a. While CPT-4 codes are reported on the UB92 and the 837I claims, the 'priority' of the CPT-4 code is completely irrelevant and not even captured. The process of adding CPT codes to a patient's account can either be accomplished by a Medical Records Abstractor entering the CPT code directly on the account or the CPT code is directly linked to a charge that is added to the account. We do know that certain 'procedures' have the CPT code associated with the charge and as such it is not possible to determine a priority based on CPTs linked with charges. Consequently, it will be impossible for a computer system to determine the 'principal' CPT procedure. As we see it, OSHPD has two options to resolve this problem – either eliminate the 'principal' procedure field or force hospitals to Medical Records Abstract more procedures than they currently do now. We don't believe this second option will be well received by the hospitals as they would have to incur considerable cost to implement it.
    b. Without a clear delineation of what OSHPD considers a 'CPT-4 procedure', all CPT codes will be reported. This will result in simple lab work or X-ray CPT codes getting erroneously reported as 'procedures'. Given the number of 'Other Procedure' fields, this may not be a major concern, but there is a risk that all real 'procedures' may not be reported because of the field limitations. The way to resolve this is to clearly define the range of CPT-4 codes that are considered procedures. This solution also ties back to the solution identified in Item 1 above.

To summarize:

1. The "loose" definition of ambulatory surgery patients will result in the reporting of inconsistent data from the hospitals.
2. CPT-4 codes on patient records are not prioritized and therefore the identification of the 'principal procedure' is not possible. Secondly, without a clear definition of what is considered a procedure, all CPT codes will be reported as procedures.

Thank you for reviewing our concerns. We believe the intent of the California Legislature is to obtain accurate and complete ED and Ambulatory Surgery data so that informed decisions can be made in the development of new processes and programs. In order to accomplish this, the requirements for reporting the ED and Ambulatory Surgery data must be very clear and concise. Should you have any questions or wish to discuss this further, please do not hesitate to contact me at (703) 736-2961 or via email at ecramer@quadramed.com.

Sincerely,
Elizabeth Cramer
Product Analyst

Cc: Irene Ogbonna, OSHPD

Response:

Thank you for your comments regarding OSHPD's proposed changes to Patient Data Reporting Requirements (Title 22, Division 7, Chapter 10 - Health Facility Data, Article 8).

The ambulatory surgery procedures definition proposed by OSHPD (procedures performed on an outpatient basis in the general operating rooms, ambulatory surgery rooms, endoscopy units or cardiac catheterization laboratories of a hospital or free standing ambulatory surgery clinic) was taken directly from the California Health and Safety Code, as stated in Section 128700. OSHPD, limited by that text, cannot propose regulations that are contrary to that language. A regulation cannot alter, amend, enlarge, or restrict a statute, or be inconsistent or in conflict with a statute. The ambulatory surgery definition proposed by OSHPD does, therefore, have the effect that OSHPD cannot require the reporting of procedures such as bone marrow aspirations being performed in an outpatient cancer clinic, biopsies being performed in a radiology department or pathology department, or angiography performed in a Radiology department.

The "Principal Procedure" field exists because it is one of the data elements specifically listed in Sections 128736 and 128737. It is not OSHPD's intent to create unnecessary difficulties for reporting facilities. OSHPD is constrained in what it can and cannot propose. A regulation cannot alter, amend, enlarge, or restrict a statute, or be inconsistent or in conflict with a statute. Thus, OSHPD proposes the definition for reporting a patient's principal procedure based on the given statutory text.

The patient's principal procedure is one that is surgical in nature, or carries a procedural risk, or carries an anesthetic risk. The procedure related to the principal diagnosis, as the chief reason for the encounter, shall be selected as the principal procedure. The procedure shall be coded according to the Current Procedural Terminology, Fourth Edition (CPT-4).

California Code of Regulations Section 97263 requires that "All significant procedures are to be reported. A significant procedure is one that is surgical in nature, or carries a procedural risk, or carries an anesthetic risk. Procedures shall be coded according to the Current Procedural Terminology, Fourth Edition (CPT-4)." There are two criteria that are to be applied when deciding what to report to OSHPD. The first criterion is "If the procedure was done on an outpatient basis in the qualified areas specified in the law, then report the record to OSHPD." The second criterion is to determine which of those procedures also meet the risk criterion. Both criteria should be met for OSHPD reporting.

OSHPD will accept data from any reporting entity source that meets the MIRCal format and specification requirements. Mapping from claims forms, (chargemaster) billing information, medical records, and admissions data or any

other pre-entered data-source may be possible and may reduce repeated key or manual entry of data.

OSHPD anticipates, based on many of the issues that you raise, that there will be a “learning curve” as the new data are submitted. To facilitate the addition of ED and AS data, the expanded MIRCal system will available for submission of data, on a voluntary basis, for the October to December 2004 reporting period. This is an opportunity to “try the system out” and test the mapping of data from various in-house systems. OSHPD MIRCal analysts will be available for assistance from 8 a.m. to 5 p.m., Monday through Friday, except for Official State Holidays.

Thank you for taking the time to respond to our proposed regulations. We appreciate your time and effort and hope that our response will address your concerns.

Comment:

Good Morning,

I will be adressing OSHPD in about two weeks when they
open for public comments prior to their final rule in Title 22 for
ER/Amb Surg reporting. I question the change in race/ethnicity from
Asian/Pacific to Asian seperated into it's own category ---if a pt is
admitted from ER or Amb surg do we have to requestionthe pt (if Asian
or
Pacific Islander) or will that info stay as first entered? The next
Question is our coding CPT-4 Medicare gidelines require modifiers when
applicable. Will the format only accept the 5 digit field or how does
IT handle reporting modifiers to Medicare or 3rd prty payors without
reporting modifiers to OSHPD? The last question is inregards to
canceled procedures after anesth or prior to anethesia - OSHPD wants
the
procedure reported by CPT-4 codes to the extent of the procedure
performed, which goes against Medicare requirements of reporting the
procedure (complete) with the modifier -73 or -74 with a V64.- code to
explain reason for incompletion. Again, this causes concern when the
bill will reflect one code and the OSHPD another. How can this be
done?
Ginger Cox will be calling me about these concerns, or E-mailing me.
Do you have any questions regarding this reporting? Thank you -

Minta Ozolins, Northern Inyo Hospital
To: Robin Cassidy
Cc: Judy Mosley

Comment 2:

Hi, Irene, These are my concerns. I do not know if Ginger forwarded
this to you on June 29th, or not.
Also, When coding Medicare screening colonoscopies, the G0121 and
G0105 codes are used. If you do not accept "G" codes, how would these
colonoscopy procedures be abstracted? Is there a way IT would convert
these "G" codes to the diagnostic colonoscopy codes from their side?

Thank you, Minta

>>> "Minta Ozolins" <> 8/23/2004 10:46:19 AM >>>

Response:

Thank you for your comments regarding OSHPD's proposed changes to Patient Data Reporting Requirements (Title 22, Division 7, Chapter 10 - Health Facility Data, Article 8).

Public comments and responses are intended to resolve questions based on the actual text of the regulations whereas most of your questions, while raising valid issues, do not address regulatory text issues. Several of your technical questions have been given to your PDS analyst who will work with you to resolve your technical issues outside of the Public Comment forum.

The race/ethnicity reporting for Emergency Department (ED) and Ambulatory Surgery (AS) must meet the data element requirements if the data are to be accepted. Each facility will determine the most appropriate way to provide acceptable data.

Section 128737 of the California health and Safety code states that each hospital and freestanding ambulatory surgery clinic shall file an ambulatory surgery data Record for each patient encounter during which at least one ambulatory surgery procedure is performed. This may affect several types of cancelled procedure scenarios as described in CPT modifiers 73 and 74.

For those encounters where an ambulatory procedure was not performed, you are not to report the AS record to OSHPD.

If a procedure is begun, but cannot be completed, report the record to OSHPD showing the CPT procedure code. Because OSHPD is not collecting modifiers, we expect that the V64 code from ICD-9-CM as an Other Diagnosis be used to explain the reason for the incomplete procedure.

OSHPD has learned from facilities that modifiers are not used consistently for the same procedures due to inconsistencies between different payers' instructions leading to conflicting data from inconsistent uses of modifiers. CMS, AMA, AHA, and the CHA Payer Committee are all attempting to determine ways to make sure the modifiers are being applied consistently, regardless of payer requirements. Note that the 3M APG (not APC) grouper will similarly not accept modifiers.

Regarding accepting information from various departments within your facility, OSHPD will accept data from any source that meets the MIRCal format and specification requirements. Mapping from claims forms, (chargemaster) billing information, medical records, admissions data or any other pre-entered data-source may be possible and may reduce repeated key or manual entry of data. Data extraction from other (electronic claims) records currently collected by your hospital may be used to provide data content for the ED and AS records.

Thank you for taking the time to respond to our proposed regulations. We appreciate your time and effort and hope that our response will address your concerns.

Comments:

"Virginia Fox" 8/19/2004 3:14:23 PM
My main concern is that there is a difference in some of the data definitions between inpatient and AS/ED data definitions, specifically for race and ethnicity. Although we should be able to map correctly depending on the type of admission, having a difference in the definitions increases the risk of error which would provide inaccurate data. The definitions to these fields should be identical.

Virginia Fox, M.S., RHIA
Regional Director, Health Information Management
St. Joseph Health System-Humboldt County

Response:

Thank you for your comments regarding OSHPD's proposed changes to Patient Data Reporting Requirements (Title 22, Division 7, Chapter 10 - Health Facility Data, Article 8).

OSHPD shares your concern that the data differences need to be addressed. The race and ethnicity difference of data definition issue that you raise is caused by OSHPD's proposing concurrent use of its established proprietary data set for inpatient data and a different data set for Emergency Department (ED) and Ambulatory Surgery (AS) data. The regulations were written to implement, interpret, and make specific the provisions of Sections 128736 and 126737. These sections of the Health and Safety Code come from SB1973, (Maddy), the law that was passed in 1998 requiring the collection of Emergency Department and Ambulatory Surgery data using a national standard data set. OSHPD would like to migrate the inpatient data to the national standard data set at some time in the future.

Thank you for taking the time to respond to our proposed regulations. We appreciate your time and effort and hope that our response will address your concern.

Comments:

Good Morning Irene

Here are some questions we have about the ED and AS data. Thanks!

Are cpt codes in the surgical range the only cpt codes reported?

What is included in AS patients, OB checks? Interventional radiology (all or just some)? Heart caths, nephrostomy tube checks, angiograms (no surgical cpt just x-ray cpt)? 23 hour observation patients?

If cpt codes are pulled from the chargemaster how does OSHPD determine which
one is the principal cpt code?

E-code, how many times do you report it, for example burns that keep coming back to the ER for wound care? Just on the initial or on all?

If patient was initially treated at another ER and then comes to our ER for followup treatment do we pick up the e-codes? If we were to pick up e-codes on each visit, there could be inconsistencies based on how MD describes the injury.

Hello again.Here are a few more questions. Thanks

1. Should patients that are seen in the ED and subsequently become observation patients be reported under the ED requirements?
2. In our endoscopy suite we have some cases that are performed in which the patient does not have any form of anesthesia or carry any major risk, should these be reported? (eg, PH monitoring, capsule endoscopy)
3. Our mechanism for coding ambulatory procedures vary depending upon where the surgery is performed. In the majority of situations the Medical Record Department codes both the diagnosis and procedures; in other situations the Medical Record Department codes the diagnosis, while the Department where the procedure was performed, codes the procedure. We are concerned that we will have difficulties in collecting information from both areas for the purposes of OSHPD reporting. Will you be able and willing to accept information from the billing record?

Claudia Donithan, RHIT, CCS
Coding Compliance Manager
John Muir Mt. Diablo Health System

Response:

Thank you for your comments regarding OSHPD's proposed changes to Patient Data Reporting Requirements (Title 22, Division 7, Chapter 10 - Health Facility Data, Article 8).

Public comments and responses are intended to resolve questions based on the actual text of the regulations whereas most of your questions, while raising valid issues, do not address regulatory text issues. Several of your technical questions have been given to your PDS analyst who will work with you to resolve your technical issues outside of the Public Comment forum.

Any CPT code will be accepted if it is performed on an outpatient basis in any of the following areas: general operating rooms, ambulatory surgery rooms, endoscopy units, or cardiac catheterization laboratories of a hospital or a freestanding ambulatory surgery clinic. *Quick Notes'* issue #5 will answer the rest of this question (i.e. observation patients).

AS encounters must meet two conditions: the procedure is performed on an outpatient basis, and the procedure is performed in one of the specified areas (general operating rooms, ambulatory surgery rooms, endoscopy units, or cardiac catheterization laboratories of a hospital or a freestanding ambulatory surgery clinic). We cannot mandate data collection from any other areas, no matter how invasive the procedure is. Once both of the above criteria are met, then your facility will follow the proposed regulations for principal and other procedures regarding the surgical risk, procedural risk, and/or anesthetic risk.

Principal Procedure: The patient's principal procedure is one that is surgical in nature, or carrries a procedural risk, or carries an anesthetic risk. The procedure related to the principal diagnosis, as the chief reason for the encounter, shall be selected as the principal procedure. The procedure shall be coded according to the Current Procedural Terminology, Fourth Edition (CPT-4).

Other Procedures: All significant procedures are to be reported. A significant procedure is one that is surgical in nature, or carries a procedural risk, or carries an anesthetic risk. Procedures shall be coded according to the Current Procedural Terminology, Fourth Edition (CPT-4).

OSHPD does not determine which CPT code is the principal CPT code. You may want to work with your programmers to use the chargemaster or the billing system for retrieving procedure codes and offer guidance regarding the principal CPT code.

An e-code should be reported on the initial record. As far as coding the burns on those seen repeatedly in ER for wound care, if these are coded with V58.43 or V58.77 we would not look for the E codes.

If an injury is the same injury, only the first ER codes the E code (where it was first diagnosed), even though the treatment was done elsewhere (i.e. your ER).

Regarding accepting information from various departments within your facility, OSHPD will accept any data that meets the OSHPD required MIRCal format and specifications. In the same way that each hospital currently designates persons to submit the discharge or inpatient data, each facility may designate persons that it chooses to submit the Emergency and Ambulatory Surgery data. A facility may change its primary contact or MIRCal system account holders at any time by following the same process that is currently used for the inpatient data.

Thank you for taking the time to respond to our proposed regulations. We appreciate your time and effort and hope that our response will address your concerns.

Comment:

I am writing these comments on behalf of Children's Hospital and Health Center, San Diego. We have spent time reviewing the proposed ED and AS data reporting requirements and we have the following concerns:

1. Disposition of Patient Query Responses:
We propose that the responses match the responses required for Inpatient data reporting. Since we share one dictionary, it is difficult to have two different dictionaries for the patient disposition. In addition, if these codes must be different, some of the categories are difficult to interpret. What is 64 - Discharged/transferred to a nursing facility certified under Medicaid (MediCal) but not certified under Medicare? Why not group all of the Home Care providers together (08 and 06), rather than having us report if the Home Care provider is for IV only?

2. Expected Source of Payment Query Responses:
As above, we propose that the responses match the responses required for Inpatient data reporting since we share one dictionary. The new proposed responses are virtually impossible to report accurately.

3. Race and Ethnicity Query Responses:
As above, we propose that the responses match the responses required for Inpatient data reporting, since we share one dictionary. To split out Asian from the Asian Pacific Islander makes reporting data collection confusing for registration staff.

Also, in order for us to report data to OSHPD accurately in 2005 for patients we are going to be seeing in Oct of 2004 (in one month) we do not have the time we need to get our dictionaries revised and get staff trained. We suggest that data reporting being with the Jan 2005 data.

Please let me know if you have any questions.

Sincerely,

Andra Marino, RHIA
Systems Analyst, Health Information Department
Children's Hospital and Health Center

Response:

Thank you for your comments regarding OSHPD's proposed changes to Patient Data Reporting Requirements (Title 22, Division 7, Chapter 10 - Health Facility Data, Article 8).

Your request "that the responses match the responses required for Inpatient data reporting" is a request that makes intuitive sense. The reason that OSHPD is proposing concurrent use of the long-established proprietary data set for inpatient data and a different data set for Emergency Department (ED) and Ambulatory Surgery (AS) data lies in the legislation (SB1973, Maddy) that was passed in 1998 requiring the collection of Emergency Department and Ambulatory Surgery data. SB 1973 was incorporated into the California Health and Safety Code in Sections 128736 and 128737 which state that Emergency Department and Ambulatory Surgery data shall be reported to OSHPD using a National Standard. The proposed regulations were written to implement, interpret, and make specific the provisions of Sections 128736 and 126737.

After considering several national standard data sets OSHPD chose the *837 Health Care Service Data Reporting Guide (HCSDRG).* OSHPD hoped to facilitate addition of ED and AS reporting by using the ANSI X12 national standard 837 HCSDRG because it is compatible with the format of other 837 Health Care Claim transaction set standards that are currently used by facilities to electronically submit claims. Creating a mapping table from an 837 Claim format to the 837 HCSDRG format should resolve many reporting issues.

Other factors that influenced OSHPD's decision to use the 837 HCSDRG include HIPAA compatibility and the fact that the reporting guide also includes other data elements that OSHPD is mandated to collect. For example, while diagnosis and procedure codes are in the claim standard the "race and ethnicity" are data elements missing from the national claims standard.

OSHPD is able to respond favorably to your last comment requesting that reporting begin with the January 1 to March 31, 2005, data that will be due May 15th, 2005. Attached at the end of this response is the text of a letter from Michael Kassis, dated September 10th, 2004, that explains that full implementation of the expanded phase of MIRCal will occur with first quarter 2005 data. Reporting for the fourth quarter of 2004 will be entirely voluntary. There will be no penalties for not reporting fourth quarter data.

Thank you for taking the time to respond to our proposed regulations. We appreciate your time and effort and hope that our response will address your concerns.

oshpd "Equitable Healthcare Accessibility for California"
Office of Statewide Health Planning and Development

Healthcare Information Division
818 K Street, Room 300
Sacramento, California 95814
(916) 323-1293
FAX (916) 322-1693
www.oshpd.ca.gov/hid

September 10, 2004

Dear Hospital or Clinic Administrator:

I am sure you are aware that the Office of Statewide Health Planning and Development (OSHPD) will begin the collection of emergency department and ambulatory surgery data in February of 2005. We refer to this as the expanded phase of MIRCal – Medical Information Reporting for California. The data to be reported will cover patients seen during the last quarter of 2004 (October – December).

I am writing to inform you that because of a delay in the regulation adoption process, the regulations governing the expanded phase of MIRCal will not become effective until late November. While we do not expect any substantial changes from the draft regulations we circulated earlier, OSHPD will not impose this reporting requirement on facilities without officially adopted regulations. Nevertheless, OSHPD will continue with development and implementation and will open the system for reporting of fourth quarter 2004 data shortly after the first of the year.

I encourage you to gather and report your data for this first cycle anyway. This will give you an excellent opportunity to test your reporting systems with extra support and assistance from OSHPD. There will be no penalties invoked for non-reporting of fourth quarter 2004 data and no fees will be assessed of clinics for 2004 data.

Full implementation of the expanded phase of MIRCal will occur with first quarter 2005 data. Roll out to all facilities will begin in March of 2005 and data will be officially due to OSHPD on May 15, 2005.

Thank you for your patience and understanding and for the tremendous support and input you and your staffs have provided and continue to provide in the development of MIRCal.

If you have any questions regarding this subject, please feel free to contact the MIRCal project manager, Starla Ledbetter, at (916) 327-5839 or sledbett@oshpd.ca.gov.

Thank you.

Sincerely,

Michael G. Kassis
Deputy Director

cc: Facility Contact

Comments:

RE: EMERGENCY CARE AND AMBULATORY SURGERY DATA SUBMISSION

Dear Ms. Diamond:

This letter is being written in response to the proposed regulatory action to require the collection and submission of Emergency Care and Ambulatory Surgery data to OSHPD via the MIRCal online transmission system. After analyzing both OSHPD's data element definitions and our operational processes, we have identified the following items as areas of concern.

1. **Definition of Ambulatory Surgery:** The California Code of Regulations, Title 22, Division 7, Chapter 10, Article 8, Paraagraph 97213, currently defines Ambulatory Surgery as "procedures performed on an outpatient basis in the general operating rooms, ambulatory surgery rooms, endoscopy units or cardiac catheterization laboratories of a hospital or free standing ambulatory surgery clinic." For hospitals, this means that the ASC population must be identified and reported based on <u>where</u> a procedure is performed. This method of identification is next to impossible for most computer systems. In our facility, angiograms can be performed either in our cardiac cath lab or in our Radiology department. Biopsies may be performed either in a surgical suite or in our Radiology department. Based on the existing AS definition, we would only report angiograms performed in our cath lab, and biopsies performed in our surgical suites. Rather than basing an AS definition on <u>where</u> the procedure is performed, it might be more appropriate for OSHPD to identify either a range of CPT codes or UB Revenue codes for identification purposes.

2. **Inconsistency of Data Elements between Inpatients and ASC/ED patients:** While it is commendable that OSHPD is committed to following the national 837 Health Care Service Data Reporting guidelines for ASC and ED reporting, the inconsistencies between the <u>same</u> data elements for inpatients vs. ASC/ED patients poses a real problem for acute care hospitals. Over the years, hospitals have incurred significant programming costs in order to map and/or translate inpatient data elements into OSHPD-specific codes and formats. Since the inpatient data elements currently do not conform to the National Standards, additional programming must now be done to translate previously customized data elements into different codes for ASC and ED patients. Examples include (but are not limited to):

   Date of Birth format: For Inpatients, mmddccyy.
   For ASC/ED, ccyymmdd.

   Unknown Date of Birth: For Inpatients, estimated year, 00 for month, 00 for day.

For ASC/ED, estimated year, 01 for month, 01 for year.

Patient Sex: For Inpatients, 1=Male, 2=Female, 3=Other, 4=Unknown.
For ASC/ED, M=Male, F=Female, U=Unknown.

Unknown Zip Code: For Inpatients, XXXXX.
For ASC/ED, 99999.

Foreign Zip Code: For Inpatients, YYYYY
For ASC/ED, (apparently) Patient's residence, first 5 digits.

Homeless Zip Code: For Inpatients, ZZZZZ.
For ASC/ED, (apparently) null.

Ethnicity: For Inpatients, 1=Hispanic, 2=Non-Hispanic, 3=Unknown.
For ASC/ED, E1=Hispanic, E2=Non-Hispanic, 99=Unknown.

Race: For Inpatients, there are 6 allowable 1-digit numeric codes.
For ASC/ED, there are 7 allowable 2-digit alphanumeric codes. It appears we need to separately identify Native Hawaiians or Other Pacific Islanders but only if the patient presents in the ED or ASC.

Would it not be more logical to have one standard within OSHPD that conforms to the National Standards, rather than two different sets of codes and formats based solely on patient populations?

3. **Definition of Service Date:** There is one field for Service Date. However, it's entirely possible that a patient will present in the ED late at night, be kept for Observation (as an outpatient) overnight, then dispositioned the next day. An ASC patient may have a surgical procedure on their Arrive Date, be kept overnight for observation, then dispositioned the following day. In these cases, our system will record both an Arrive Date and a (next-day) Disposition Date. Which date is OSHPD expecting in the Service Date field?

To summarize:

1. The "loose" definition of ASC patients (based on where a procedure is done) poses significant problems to hospitals who must try to identify these patients for reporting purposes. Perhaps a definition based on CPT Code(s) or UB Revenue Code(s) would be more appropriate.
2. The inconsistency of data element definitions, codes and formats between inpatients, ASC and ED patients will result in staff confusion, programming costs, and potential errors in both hospital reporting and OSHPD data analysis. Perhaps inpatient data elements should be brought into conformity with National Standards prior to implementing ASC/ED data collection.

3. The definition of Service Date needs to be clarified for those cases where the Disposition Date is different from the Arrive Date.

Thank you for reviewing our concerns. We realize that the collection of ED and ASC data in California is important for many reasons, and we are most encouraged that OSHPD intends to move to the 837 National Data Standards. However, having to report two separate sets of data elements, codes and formats, one for inpatients and one for ASC/ED patients, will pose considerable difficulties for Methodist Hospital unless the above issues are addressed and resolved.

Sincerely,

Dennis Lee, CEO
Kay Berglund, CFO
Brigitte Didier, HIM Director
Jerilin Cummings, PFS Director
Barbara Ower, I.S. Database Manager

Methodist Hospital

Response:

Thank you for your comments regarding OSHPD's proposed changes to Patient Data Reporting Requirements (Title 22, Division 7, Chapter 10 - Health Facility Data, Article 8).

The ambulatory surgery procedures definition proposed by OSHPD (procedures performed on an outpatient basis in the general operating rooms, ambulatory surgery rooms, endoscopy units or cardiac catheterization laboratories of a hospital or free standing ambulatory surgery clinic) was taken directly from the California Health and Safety Code, as stated in Section 128700. OSHPD cannot propose regulations that are contrary to that language. A regulation cannot alter, amend, enlarge, or restrict a statute, or be inconsistent or in conflict with a statute. The ambulatory surgery definition proposed by OSHPD does, therefore, have the effect that OSHPD cannot require the reporting of procedures such as bone marrow aspirations being performed in an outpatient cancer clinic, biopsies being performed in a radiology department or pathology department, or angiography performed in a Radiology department.

The "inconsistency of data element" issues that you raise appear due to OSHPD's proposing concurrent use of established definitions in the data set for inpatient data and definitions based on national standards for Emergency Department (ED) and Ambulatory Surgery (AS) data. The regulations were written to implement, interpret, and make specific the provisions of Sections 128736 and 126737. These sections of the Health and Safety Code require that Emergency Department and Ambulatory Surgery data be reported to OSHPD using a national standard. Data extraction from electronic claims currently required of your hospital may be available to provide data content for the ED and AS records. OSHPD would like to migrate the inpatient data to a similar national standard data set at some time in the future.

After considering several national standard data sets OSHPD chose the *837 Health Care Service Data Reporting Guide (HCSDRG).* OSHPD is facilitating the addition of ED and AS reporting by using the ANSI X12 national standard 837 HCSDRG because it is compatible with the data content of other 837 Health Care Claim transaction set standards that are currently required to submit electronic claims. The HCSDRG was designed for use by public health entities. Extracting from an 837 Claim format to the 837 HCSDRG format should resolve issues for submission to OSHPD.

Other factors that influenced OSHPD's decision to use the 837 HCSDRG include HIPAA compatibility and the fact that the reporting guide also includes other data elements that OSHPD is mandated to collect. For example, while diagnosis and procedure codes are in the claim standard the "race and ethnicity" are missing from the national claims standard.

A facility may have several computer systems with varying degrees of compatibility. OSHPD, while unable to provide software or mapping solutions for facilities, will accept data from any source that meets the MIRCal format and specification requirements. Mapping from claims forms, (chargemaster) billing information, medical records, admissions data or any other pre-entered data-source may be possible and may reduce repeated key or manual entry of data. Part of the reason behind using a national standard data set was to reduce multiple entry situations.

The service date reported to OSHPD should be the 'start of care' date. It may be known as the "From Date" or "Begin Date" in billing.

OSHPD anticipates, based on many of the issues that you raise, that there will be a “learning curve” as the new data are submitted. To ease the transition, the expanded MIRCal system will available for submission of data, on a voluntary basis, for the October to December 2004 reporting period. This is an opportunity to “try the system out” and test the mapping of data from various in-house systems. OSHPD MIRCal analysts will be available for assistance from 8 a.m. to 5 p.m., Monday through Friday, except for Official State Holidays.

Thank you for taking the time to respond to our proposed regulations. We appreciate your time and effort and hope that our response will address your concerns.

Comments:

It has been a number of years since OSHPD notified facilities that the collection of ED\AS data would be required for submission to OSHPD. Healthcare facilities trying to anticipate those regulatory requirements began collecting the data to assure compliance with the mandate. OSHPD has provided very few guidelines for the data collection in the interim, so facilities have used inpatient data standards and tables to build the ED/AS fields.

Changing and programming electronic systems to meet the regulatory requirements on the new ED/AS data elements, new patient types, etc., can take months to complete. Training staff to collect the data, at point of entry, registration, nursing, or clinic levels also takes time. There is also a period of acceptance of the new regulatory requirement, as well as a learning curve to collect the data accurately.

Healthcare organizations have integrated systems, with many interfaces between departments over a period of many years. The data element tables are long established and mapped based on the inpatient OSHPD criteria and Medicare requirements. Most existing systems only allow one table and mapping scenario per data element.

Consistency of data and mapped values is very important. The fact that data elements that currently exist in the Inpatient model, have different values and formats in the ED\AS model is problematic . The mapping requirements in the ED\AS specifications will impact healthcare facilities by the following:

1. Enormous potential financial outlay to change systems to meet the requirements.
2. Inability to meet the requirements with current systems - requiring facilities to purchase and or modify existing systems or services.
3. Increases in staff to maintain dual mechanisms and the creation of workarounds to report ED\AS data.

OSHPD should bear in mind that there is currently a huge State and local county budget crisis that prevents facilities from making major system changes or adding staff to do workarounds on non-standard data requirements. The fact that final regulations are still not available is disconcerting. How are facilities to provide guidance and commitment to staff collecting the data, when OSHPD has not completed the requirements?

NON standard Fields At Issue:
Date of Birth - The year format reversal will cause presentation problems

for IT Departments as in most systems years are formatted MMDDYYYY not as OSHPD is proposing YYYYMMDD.
Sex - Different values from inpatient may cause mapping issues for some facilities collecting inpatient data in the same systems.

Race - Different values from inpatient may cause mapping issues for some facilities collecting inpatient data in the same systems.

Ethnicity - Different values from inpatient may cause mapping issues for some facilities collecting inpatient data in the same systems.

Service Date - The year format reversal will cause presentation problems for IT Departments as in most systems years are formatted MMDDYYYY not as OSHPD
is proposing YYYYMMDD.

Disposition of Patient - Different values from inpatient may cause mapping issues for some facilities collecting inpatient data in the same systems.

Expected Source of payment - The source of payment for inpatient is 5 digits (due to the Type of Coverage and Name of Plan) and ED\AS is a 2-digit field.

Santa Clara County Health and Hospital System like many facilities, had to map the source of payment at the actual health plan level in order to report this data element to OSHPD. Santa Clara County Health and Hospital System has less of a burden than most, as we only have 800 plans, but a lot of facilities have over 1,000 plans that they had to map quite extensively, and have to maintain for OSHPD reporting.

Thank you.

Karen Bolding MS, RHIA
Sr. Management Information Systems Analyst
Santa Clara Valley Health and Hospital System

Response:

Thank you for your comments regarding OSHPD's proposed changes to Patient Data Reporting Requirements (Title 22, Division 7, Chapter 10 - Health Facility Data, Article 8).

OSHPD publicly notified facilities that the collection of ED\AS data in national standard format would be required for submission to OSHPD as early as March 2002 when the MIRCal Outreach Team (Candace Diamond, Cheri Hummel, RHIT, Irene Ogbonna, and Ginger Cox, RHIT, CCS) presented, "MIRCal Expansion: The Collection of ED/ASC Data" in 5 Cities (Sacramento, Pleasanton, Long Beach, San Diego, and Fresno). We have also conducted 6 surveys over the last couple of years. OSHPD provided very few guidelines for the data collection in the interim because we were researching a variety of National Standards to assess which National Standard would best meet the data collection required by statute (SB 1973, Maddy, 1998) and which would also cause least collection effort on the part of impacted facilities. It became clear that OSHPD could not fulfill the mandate of SB 1973 by selecting a National Standard that would encompass our established Discharge (Inpatient) Data set and that National Data Standards occasionally had different data definitions for some similarly named data elements.

After considering several national standard data sets OSHPD chose the *837 Health Care Service Data Reporting Guide (HCSDRG).* OSHPD hoped to facilitate addition of ED and AS reporting by using the ANSI X12 national standard 837 HCSDRG because it is compatible with the data content of other 837 Health Care Claim transaction set standards that are currently used by facilities to submit claims. Extracting from an 837 Claim format to the 837 HCSDRG content should resolve your stated issues for submission to OSHPD.

Other factors that influenced OSHPD's decision to use the 837 HCSDRG include HIPAA compatibility and the fact that the reporting guide also includes other data elements that OSHPD is mandated to collect. For example, while diagnosis and procedure codes are in the claim standard the "race and ethnicity" are missing from the national claims standard.

Your comment that "There is also a period of acceptance of the new regulatory requirement, as well as a learning curve to collect the data accurately," while not a comment specific to the regulatory text, is a matter of concern for OSHPD. In addition to factors discussed in earlier paragraphs, we intend to make the MIRCal system available for submission of data on a voluntary basis for the October to December 2004 reporting period. This is an opportunity for all facilities that would like to "try the system out." OSHPD MIRCal analysts will be available for assistance from 8 a.m. to 5 p.m., Monday through Friday, except for Official State Holidays. Further, it is OSHPD's intent to continue the current business practice that MIRCal is updated and opened for the submission of data

well before a report period due date. MIRCal was open and available for the submission of inpatient data on July 22, 2004, for a due date of September 30, 2004. OSHPD encourages and allows unlimited "Test" data submissions that allow a facility to receive online feedback (usually within a few hours of submission). This system works so well for Inpatient data that by Monday, September 27th, 458 (97.7% of an expected 469 reports) hospitals had submitted at least one test data file. Of these, 343 hospitals had data that had been formally submitted and formally approved, 24 were approved on the test system but had not yet formally submitted, and 91 had data that had been submitted but did not yet meet approval criteria and was still being corrected. OSHPD is confident that ED and AS data providers will be able to use MIRCal to produce similar results.

You comment that "Healthcare organizations have integrated systems, with many interfaces between departments…" prompts the response that OSHPD is aware that the national standard for ED and AS data differs from the long-established OSHPD data set (developed from UHDDS standards and proprietary changes made by OSHPD) for inpatient data. The regulations were written to implement, interpret, and make specific the provisions of Sections 128736 and 126737. These sections of the Health and Safety Code require that Emergency Department and Ambulatory Surgery data be reported to OSHPD using a national standard. Data extraction from other (electronic claims) records currently collected by your hospital may provide data content for the ED and AS records. OSHPD would like to migrate the inpatient data to the national standard data set at some time in the future. This migration is not possible at this time and falls outside the scope of the currently proposed regulations.

Further you comment that "Consistency of data and mapped values is very important." OSHPD agrees that consistent data is important. The issue of fiscal impact was a relevant factor in OSHPD decision-making and was one of the factors that led to the selection of the 837 format that is already used by any facility that is filing electronic claims. OSHPD considered that the length of time between the passage of the law, the six surveys, the outreach activities and the proposed regulations gave facilities some time to become compliant with HIPAA requirements and thus already have these data available using the national standards.

The voluntary reporting opportunity addresses your concerns regarding giving facilities greater time to resolve requirements concerns. Data will not be required to be submitted until the January1 through March 31 reporting period due May 15, 2005. MIRCal will be available for data testing and formal data submission several weeks before the due date.

Thank you for taking the time to respond to our proposed regulations. We appreciate your time and effort and hope that our response will address your concerns.

Comment:

Candace L. Diamond
Manager, Patient Data Section
Office of Statewide Health Planning and Development
818 K Street, Room 100
Sacramento, CA 95814

Dear: Ms. Diamond:

Kaiser Permanente would like to take this opportunity to comment on the proposed inclusion of Emergency Care and Ambulatory Surgery data through the Medical Information Reporting for California (MIRCal) system.

In theory, the addition of patient data from emergency departments and ambulatory surgery centers would more accurately reflect overall utilization of healthcare services, and (possibly) aid in planning, designing, and conducting future studies on use of services and selected clinical outcomes. In practice, we have a number of concerns about the feasibility of complete and accurate data collection within the time frame specified in the proposal. These concerns reflect issues over which hospitals may have some control, as well as broader challenges over which many hospitals have little or no control, at least in the short run. The following summarizes our concerns and recommendations.

Technical impediments

- In both the ED and AS settings, a number of required data elements, although collected, currently employ *value categories* that are different from those specified in the proposal. In Kaiser Foundation Hospitals, "Race", "Disposition of Patient", and "Expected Source of Payment" employ value categories different from those specified. Changing these value categories is not trivial. The data are collected in either of two different computer systems (our admission/registration system and our discharge system). The vendor responsible for maintaining our discharge computer system is unable to accommodate changes to the value categories in the time frame specified. More importantly, internal programming staff assigned to designing and implementing Kaiser's fully integrated electronic medical record would need to be diverted from that critical patient-care function to modify value categories for a discharge data system scheduled to be replaced. This is difficult to justify from either a business standpoint or a patient care perspective.

- Many hospitals – including most Kaiser Foundation Hospitals – do not completely or reliably distinguish principal from secondary or other diagnoses in the ED setting. The same holds for distinguishing principal from other external causes of injury, as well as principal from other procedures. The

reason is simple: Emergency Departments are very busy places, where patient care is the highest priority, and medical records reflecting the patient's previous clinical history are largely unavailable. In the absence of a complete clinical history or follow-up information, distinctions between "principal" and "other" diagnoses in the ED setting are largely speculative. Kaiser Permanente's electronic medical record will go far toward addressing this problem by providing the ED physician with the patient's previous clinical history, as well as a robust and accurate method to distinguish principal from secondary or other diagnoses, but the electronic medical record will not be deployed in our ED's by the scheduled implementation date for the proposed changes to MIRCal.

Operational impediments

- With more and more community hospital Emergency Departments closing their doors, there is an ever-increasing amount of ED saturation. In many communities, ED's are increasingly being placed on divert status, with their neighbors having to accept an increasing caseload. Compounding this situation is a California economy in which the uninsured seek primary care in ED's, adding to the demands for services and care, and decreasing the amount of focus, education, and staff time needed to implement the proposed data requirements.

As noted above, Kaiser Permanente is in the process of implementing a massive project to create and maintain electronic medical records for each of its patients in all settings, including ED and ambulatory surgery. The electronic medical record, with its professional and hospital billing modules, will greatly enhance our ability to capture encounter data. The resource constraints needed to support an interim change management process, including training, education, and compliance monitoring, to remediate our current encounter capture system is not feasible, given the large scale ($5 billion) organizational commitment to our electronic medical record.

<u>Recommendation</u>

Kaiser Permanente recommends that the implementation timeline for the new data requirements for Emergency Department and Ambulatory Surgery be delayed. This will provide hospitals an opportunity to address at least the technical impediments to implementation within the time frame noted in the proposal. With the phased implementation of our electronic medical record, our ability to meet the new data requirements will improve over the span of implementation. We recognize that the operational impediments may be largely insoluble but a delay of four years would largely resolve the technical impediments.

Once again, Kaiser Permanente strongly supports the underlying intent of the proposed new data elements, and looks forward to working with OSHPD and other California hospitals to assure this is done in a manner and time frame consistent both with good patient care and the collection of complete and accurate data.

Sincerely,

For Kaiser Permanente Northern California:		For Kaiser Permanente Southern California:	
Mary Ann Thode President of Northern California Region Kaiser Foundation Health Plan, Inc. Kaiser Foundation Hospital	Robert Pearl Executive Director and CEO, The Permanente Medical Group	Ray Baxter Interim President Southern California Region Kaiser Foundation Health Plan, Inc. Kaiser Foundation Hospital	Jeff Weisz Medical Director Southern California Permanente Medical Group

Comment:

Ms. Candace L. Diamond
Manager, Patient Data Section
Office of Statewide Health Planning and Development
818 K Street, Room 100
Sacramento, CA 95814

Dear Ms. Diamond:
Kaiser Permanente understands that the letter we submitted on October 1, 2004 cannot adequately communicate the issues around the new reporting requirements. We would like an opportunity to discuss and clarify in person those areas where we will be able to comply and strategies to bridge the elements where we may not be able to fully report accurate data. I will be contacting you shortly to arrange for a meeting with appropriate OSHPD staff to discuss our issues.

We would appreciate your deleting the October 1 e-mail with the comments. We sorry for any inconvenience this may have caused.

Sincerely,

Deb Lowry
KP HealthConnect
National Director Value Realization

----- Forwarded by Deb Lowry/PO/KAIPERM on 10/05/2004 06:30 PM -----

Patti A Harvey
10/01/2004 09:43 AM

To: MIRCal@oshpd.ca.gov
cc: Robert Pearl/ MaryAnn Thode/, Vicki George/, Dwight M Cochran/, Deb Lowry/, Patricia M Lynch/, Carolyn Days/, Jeffrey A Weisz, Michael H, Paul M Minardi, Andy M, Larry Sharfstein/, Julie M Luboviski/

Subject: Kaiser Permanente's comment on ED and ASC data regulations

Good morning,

Attached is the Kaiser Permanente response and recommendations for the Emergency Department and Ambulatory Surgery data regulations. Thank you for the opportunity to respond and comment. Please do not hesitate to contact us if additional information is needed.

Patti Harvey, RN, MPH, Practice Leader, Data Quality

Response:

-----Original Message-----
From: Irene Ogbonna [mailto:IOgbonna@oshpd.state.ca.us]
Sent: Wednesday, October 06, 2004 9:10 AM
To: Reference Attorney

Subject: Withdrawal of a Public Comment

Dear Attorney of the Day,
We concluded a Public Comment Period on October 4th. On October 5th we received a request to withdraw a comment (and instead meet in person to discuss data reporting strategies). Having not faced this situation before I am seeking confirmation that we can withdraw the comment even though the request was made after the conclusion of the comment period.
Irene Ogbonna

Irene J. Ogbonna, AGPA
Healthcare Information Division
Office of Statewide Health Planning and Development
818 K Street, Room 100
Sacramento, CA 95814
(916) 324 3851 (FAX 327 1262)
E-mail: iogbonna@oshpd.state.ca.us
Web Page: www.oshpd.state.ca.us

OAL Reply

All comments, regardless of when received, are part of the rulemaking file and must be included in the file submitted to OAL. OAL knows of no procedure to permit you to remove either the comment or the request to withdraw the comment from the rulemaking file after their submission. Since the commenter does not want to receive a formal response to the comment as part of the APA's summary and response to comment process, OAL recommends that you simply document that request in the FSR and provide no summary or response to the withdrawn comment.

OAL Reference Attorney

Comments:

Questions for OSHPD
New ED and AS Reporting Requirements

1. Why can't the dictionaries for the proposed ED and AS submissions be the same as the inpatient?
2. Why are there no values for Foreign or Homeless ZIP codes? These would be particularly important for ED patients.
3. How would we report ED accounts that get billed under the "72 hour" since charges and procedures are 'rolled' to the inpatient account.
4. There may be a problem reporting Principal Procedure codes for ED and AS cases where CPT-4 codes are hard coded in the charge master. How do we determine which CPT code is principal?
5. There is no Prison/Jail disposition for ED and AS. Why?
6. Please provide additional clarification on the Expected Source of Payment. How would we identify patients that are on disability? If the payor is Blue Cross or Blue Shield and the plan is a POS or PPO, how do we report it?

Kenneth Macklem, C.C.S
Assistant Director, Medical Coding
UCLA Healthcare

Response:

Thank you for your comments regarding OSHPD's proposed changes to Patient Data Reporting Requirements (Title 22, Division 7, Chapter 10 - Health Facility Data, Article 8).

Your question "Why can't the dictionaries for the proposed ED and AS submissions be the same as the inpatient" is a good issue to raise because that issue is the source of all of your technical questions. The reason that OSHPD is proposing concurrent use of OSHPD's long-established proprietary data set for inpatient data and a different data set for Emergency Department (ED) and Ambulatory Surgery (AS) data lies in the legislation (SB1973, Maddy) that was passed in 1998 requiring that Emergency Department and Ambulatory Surgery data be reported to OSHPD using a national standard. The proposed regulations were written to implement, interpret, and make specific the provisions of the California Health and Safety Code Sections 128736 and 126737.

After considering several national standard data sets OSHPD chose the *837 Health Care Service Data Reporting Guide (HCSDRG).* OSHPD hoped to facilitate addition of ED and AS reporting by using the ANSI X12 national standard 837 HCSDRG because it is compatible with the data content of other 837 Health Care Claim transaction set standards that are currently used by health facilities to submit electronic claims. Extracting from an 837 Claim format to the 837 HCSDRG format should resolve issues for submission to OSHPD.

Other factors that influenced OSHPD's decision to use the 837 HCSDRG include HIPAA compatibility and the fact that the reporting guide also includes other data elements that OSHPD is mandated to collect. For example, while diagnosis and procedure codes are in the claim standard the "race and ethnicity" are data elements missing from the national claims standard.

OSHPD has been in the data collecting business for several decades and has a vested interest in the highest quality data. Data extraction from other (electronic claims) records that are collected by your hospital and an expansion of your data dictionary may be able to resolve these issues.

To report ED accounts that get billed under the "72 hour" rule with charges and procedures that are 'rolled' to the inpatient account OSHPD requires that one inpatient record be reported. No change to current inpatient discharge data reporting practice is required.

The patient's principal procedure is one that is surgical in nature, or carries a procedural risk, or carries an anesthetic risk. The procedure related to the principal diagnosis, as the chief reason for the encounter, shall be selected as the principal procedure. The procedure shall be coded according to the Current Procedural Terminology, Fourth Edition (CPT-4). OSHPD cannot address the

hard-coding issue since we do not know what is hard coded at your facility. If you follow national coding guidelines and documentation requirements, you will be meeting the OSHPD reporting guidelines.

There is no Prison/Jail disposition for ED and AS because this disposition category is not included in the national standard.

Expected Source of Payment: To identify patients that are paid for by disability coverage a facility would need to offer disability as an expected source of payment option. This category is part of the national standard and no further definition is available.

If the payor is Blue Cross or Blue Shield and the plan is a POS or PPO, POS and PPO have reporting categories 13 and12 respectively.

Thank you for taking the time to respond to our proposed regulations. We appreciate your time and effort and hope that our response will address your concerns.

Comment:

Dear Sirs: I have spent precious hours reading about MIRCal's upcoming required patient reporting by surgery centers. This new requirement is unattainable by certain small, single surgeon, single specialty surgery centers. I do not have adequate staff to do the necessary data entry. If I have to comply with this new requirement, I will have to hire a new employee to perform this task. This will mean that I have to pay an additional health insurance premium, retirement benefits, Salary, and malpractice premium and . . . my facility just can afford to do that! After all my reading, I cannot determine how all of this new reporting will benefit my patients, improve the care that my staff are currently providing patients, or assure that I can pay my bills (including California State taxes and license fees). If forced to comply with this new requirement, it will be the straw that breaks my facilities' back . . . specifically our ability to survive! Is it the State's intent to force small surgery centers to either forgo State Licensure or to close them?! These appear to be my only options. Sincerely looking for your assistance with this critical matter,

Leigh Anderson, MA, BS, RN
Administrator, The Centre
9/19/2004 12:49:30 PM

Response:

Thank you for your comments regarding OSHPD's proposed changes to Patient Data Reporting Requirements (Title 22, Division 7, Chapter 10 - Health Facility Data, Article 8).

It is not OSHPD's intent to contribute to the closure of any health facility. OSHPD shares your concern regarding the rising cost of health care which is why we have proposed an 837 compatible national standard data set as the basis for the Ambulatory Surgery data set. Facilities are using the national standards for processing electronic health care claims (837 claims transactions). The 837 HCSDRG is compatible with the format of other 837 Health Care Claim transaction set standards. This should mean that many of the required data elements are already collected by your facility.

Also, OSHPD is not requiring the purchase or installation of any new software or hardware by your facility. We have expanded the MIRCal online reporting system that is currently being used to report inpatient data. OSHPD will accept data from any source that meets the MIRCal format and specification requirements. Mapping from claims forms, (chargemaster) billing information, medical records, pre-admissions data or any other pre-entered data-source may be possible and may reduce repeated key or manual entry of data.

OSHPD offers education and information on reporting requirements to any interested parties, including software and health information companies. OSHPD does not recommend or endorse any vendors or abstracting services. If your current staff lack reporting expertise and you wish to obtain assistance with reporting data to OSHPD through the MIRCal system, we are aware that there are services available to you on a contractual basis. This option may be just what you need to continue to thrive in an increasingly competitive business environment without needing to hire any more permanent staff.

The data collection initiative has been supported by a variety of organizations. OSHPD received input from California Ambulatory Surgery Association, California Health Information Association (including the Ambulatory Information Management subgroup and the Coding and Data Quality Committee), Ambulatory Surgery software vendors, the California Health Policy and Data Advisory Commission (including the Health Data and Public Information Committee with a wide range of represented constituencies), OSHPD's ED and AS Data Consortium (including major stakeholders such as freestanding clinics to represent reporting entities, information technology experts, vendors, and data users), the National Association of Health Data Organizations, and American Health Information Management Association, to mention some of the supporters.

Data users request patient data for a variety of purposes. Some current uses of inpatient data include injury surveillance and child injury prevention. Facilities also request data for internal quality assurance measuring, product development, and market-share analysis. Future uses of ED and AS data may include emergency medical service planning and analyzing trends in the utilization of Emergency Department and the Ambulatory Surgery settings. Patient data provide vital information for improving healthcare for Californians.

The expanded MIRCal system will be available for submission of data, on a voluntary basis, for the October to December 2004 reporting period. This is an opportunity to "try the system out" and test the mapping of data from various in-house systems. Facilities who voluntarily report will have greater access to limited OSHPD staff resources and will also benefit from being able to initiate in-house staff learning in the least stressful environment. OSHPD MIRCal analysts will be available for assistance from 8 a.m. to 5 p.m., Monday through Friday, except for Official State Holidays.

Thank you for taking the time to respond to our proposed regulations. OSHPD has proposed the regulations that it feels most accurately implement, interpret, and make specific the provisions of SB 1973 (as they have been written into Sections 128736 and 126737 of the California Health and Safety Code) whilst being least burdensome to most facilities. We appreciate your time and effort and hope that our response will address your concerns.

Comment:

Good Afternoon Ms. Diamond:

I am writing to you on behalf of Dr. Clayton Varga. Perhaps a simple suggestion would be if their can be a way to simplify the form. We are required to enter the same data on each patient several times, and therefore this will become repetative and inefficient.

I hope you will take this under consideration, thank you and have a great day.

Sincerely,

Clayton A. Varga, M.D.

cc: Morayma Erazo

From: Morayma Erazo
Clayton Varga, M.D ; lpeters; Mattew Talbot
Sent: Monday, August 30, 2004 2:21 PM

Response:

Thank you for your comments regarding OSHPD's proposed changes to Patient Data Reporting Requirements (Title 22, Division 7, Chapter 10 - Health Facility Data, Article 8).

OSHPD forms, or screens that are the online equivalent of forms, are used to submit a record of one inpatient visit or one emergency encounter or one ambulatory surgery encounter. None of the data elements is repeated within any form, although several diagnosis and procedure fields may be needed to report all diagnosis and procedure data. Each form consists of only the required fields and is therefore as short and as simple as is possible.

If your facility would like to map or extract patient data entered on a claim or billing form into the OSHPD format to avoid reentry of data please know that this is an acceptable practice. OSHPD will accept data from any reporting entity source that meets the OSHPD MIRCal format and specifications.

Thank you for taking the time to respond to our proposed regulations. We appreciate your time and effort and hope that our response will address your concerns.

Comment:

I would strongly suggest changing the name of the proposed required data element "Principal Diagnosis" to "First-Listed Diagnosis", which is consistent with Official Diagnostic Coding and Reporting Guidelines for Outpatient Services. According to the Uniform Hospital Discharge Data Set (UHDDS), the definition of principal diagnosis applies only to inpatients in acute, short-term, general hospitals. In the outpatient setting, the term first-listed diagnosis is used in lieu of principal diagnosis. Thank you.

Daniel J. Pothen, MS, RHIA, CPHIMS, CCS, CCS-P
Director of Medical Records/HIM Services
Mission Hospital

Response:

Thank you for your public comment regarding changing the name of the proposed data element "Principal Diagnosis" to "First-Listed Diagnosis.

OSHPD is mandated to collect data elements listed in the Emergency Department and Ambulatory Surgery data sets as they are listed in Sections 128736 and 128737 of the Health and Safety Code. The purpose of these regulations (Title 22, Division 7, Chapter 10, Health Facility Data, Article 8, ~~Discharge~~ Patient Data Reporting Requirements) is to implement, interpret, and make specific the provisions of the Health and Safety Code as they are stated (listed). OSHPD is not authorized to change the names of the data elements listed in law.

Thank you for taking the time to respond to our proposed regulations. We appreciate your time and effort and hope that our response will clarify the basis for the naming of the Principal Diagnosis data element.

Comment:

I would like to take this opportunity to express my concern about the proposed MIRCal reporting requirements. We are a small, free standing Endoscopy Center. We are state licensed, Medicare certified and soon to be AAAHC certified.

The proposed reporting requirements will be an extreme burden on our facility. We currently have just one administrative coordinator; to meet the new demands we will likely need to hire a new part time employee. We have brand new scheduling and billing software that will not interface with the OSHPD reporting form, so all data entry will be manually done. We see 12-15 patients each day, I can't imagine how a larger facility will manage.

I understand that it is important to monitor for patient complications, but this reporting tool really won't assist with that, other than the "disposition of the patient" section, and that only monitors immediate transfers, not complications that occur several days later. We are mandated by law to inform the state of all major patient complications, transfers and deaths, which we do using the CA State "Patient Transfer Reporting Form." Does the State really have the staffing to review all these new forms that will be sent in?

We have many patients that do not give their Social Security Number anymore, so this will most often be left blank. We also do not collect race information, so this will always be left blank.

This requirement will be costly for small businesses such as ourselves, unfortunately these costs will eventually be placed back onto the patients we serve. I also do not believe it will be serving the purpose for which it is intended. I think the State's money would be better utilized by hiring more inspectors and doing periodic facility inspections.

Thank you,
Molly Tinney, RN
Clinical Director

Response:

Thank you for your comments regarding OSHPD's proposed changes to Patient Data Reporting Requirements (Title 22, Division 7, Chapter 10 - Health Facility Data, Article 8).

To meet the healthcare industry and public's demand, state legislation (SB1973, Maddy) was passed in 1998 to collect Emergency Department and Ambulatory Surgery data. Sections 128736 and 128737 of the California Health and Safety Code mandate that Emergency Department and Ambulatory Surgery data shall be reported to OSHPD. These regulations were written to implement, interpret, and make specific the provisions of Sections 128736 and 126737 of the Health and Safety Code.

The California Ambulatory Surgery Association (CASA) has supported the establishment of this data collection program and was instrumental in getting the originally proposed fees down from $2.00 per record to 50 cents per record.

Regarding cost concerns, OSHPD has chosen a national data standard, the 837 Health Care Services Data Reporting Guide as mandated. This was done to minimize the cost of reporting by each facility and also to make use of data that was already being collected by Ambulatory Surgery Clinics. Time taken to make an electronic file from a subset of already collected data should not be too considerable. We have analysts who can help you and free online computer-based training to help you to submit your data through the MIRCal online reporting system. We hope that these factors will mitigate your costs so that the reporting burden will be less than you are anticipating.

Data users request patient data for a variety of purposes. Some current uses of inpatient data include injury surveillance and child injury prevention. Facilities also request data for internal quality assurance measuring, product development, and market-share analysis. Future uses of ED and AS data may include emergency medical service planning and analyzing trends in the utilization of Emergency Department and the Ambulatory Surgery settings. Patient data provide vital information for improving healthcare for Californians.

Your comments regarding the "Patient Transfer Reporting Form" are not related to the content of these regulations and are therefore beyond the scope of this public comment period.

Regarding your comment that "many patients that do not give their Social Security Number anymore, so this will most often be left blank" OSHPD would like to note that the collection of Social Security Numbers is not an optional data element. The collection of Social Security Numbers is a requirement under the California Health and Safety Code, Section 128737. This information can be

collected at the same time as other patient information is sought by your facility. OSHPD understands that there may be occurrences when Social Security Numbers are not available in the medical record (newborns, foreign nationals) however we strongly encourage facilities to ensure the collection of Social Security Numbers when possible. It has been our experience that the majority of Medicare beneficiaries are able to provide a Social Security Number. If your patient is unable to provide the Social Security Number and it is not listed on any admitting, referral, or insurance documentation and is unavailable because the patient or their care givers cannot provide it during their entire contact with your surgery center, you may report the Social Security Numbers (SSN) as unknown 00000001.

We would like to reassure you that OSHPD has been collecting SSN for over 14 years with no known security breaches. The SSN is encrypted into a record linkage number to identify readmissions and multiple encounters for the same patient over time. Patient data is submitted through a secure encrypted connection, the locations of the Patient Data Section (PDS) staff and the data warehouse are secured, and a full-time information security officer is employed by OSHPD. All data stored on OSHPD's servers are protected by Oracle advanced security. OSHPD meets and/or exceeds HIPAA security standards. The data will be protected through firewall mechanisms.

Regarding your comment that "We also do not collect race information, so this will always be left blank." OSHPD would also like to note that the collection of the Race and Ethnicity data elements are required by the California Health and Safety Code, Sections 128736 and 128737. This information can be collected at the same time as other patient information is sought by your facility and can be presented on a written form in a "Please check the box that most closely describes your Race" and a "Please check the box that most closely describes your Ethnicity" format taken directly from the OSHPD reporting form or screen. If a patient refuses to indicate their race, it is to be reported to OSHPD as "99 - Unknown".

Your comments regarding the hiring of inspectors and periodic inspections are not related to the content of the regulations that OSHPD is proposing. These comments are beyond the scope of this public comment period.

Thank you for taking the time to respond to our proposed regulations. We appreciate your time and effort and hope that our response will address your concerns.

Comment:

Today I spoke with a representative in the Capitol who reminded me that the issue here is the strong hospital lobbying groups that support and pushed this bill in an effort to add burden upon the Ambulatory Surgical Centers to drive them out of business.

Although this is not surprising, it is interesting that a State legislator sees through the bill to the real intent. If true, it should be legally probed for anti-trust issues in the guise of legislation.

Moreover, the public and the insurance carriers need education on what major players have saved them money in the healthcare arena. Most likely they will discover that the ASC's are their allies and should be protected from any legislation that jeopardizes the existence of ASC's, or reduces their cost saving potential such as SB 1973.

Below are comments previously sent to your office regarding SB 1973.

>>> "Marklin" <> 8/26/2004 11:43:55 AM >>>

(Comments sent OSHPD/MIRcal re: SB1973, data reporting)

Dear Madams, Sirs:
Although SB 1973 has been on the books for some time, the implementation and demographics required have inspired a call for logic.

One justification why Ambulatory Surgery Centers should be reporting the SB 1973 data is because Hospitals are required to. This is the fault of poor lobbying on the part of AHA, not the ASC's getting an exception or a "break".

Ambulatory Surgery Centers are paid less by MEDICARE, MEDICAL and the Commercial carriers precisely because less bureaucracy is required of them, thus cutting cost.
SB 1973 goes counter to this theory by not only requiring ASC's to report, adding additional labor cost, but charge the ASC a tax as well.

Ambulatory Surgical Centers were designed to be swift and efficient reducing cost to the entire healthcare system. The STATE does not understand this.Unlike Hospitals that are reimbursed at higher rates and can often line item bill, ASC's cannot arbitrarily pass on increased costs imposed on them by the STATE.

ASC's are not in the business of reporting on their clients. This is a violation of our right to be free of conflicting interests. We are not patient advocates if we must spy on our patients and report their very private data.

ASC's are care givers, not bureaucrats. All time diverted into bureaucracy is time diverted from patient care.

ASC's are not the ideal repositories of this information. Commercial Carriers, MEDICARE, MEDICAL and all other insurances are the IDEAL sources for this data gathering because

1) They have client information at their disposal.
2) They can easily pass on the imposed costs.
3) They are not care givers with precious resources.
4) They have more to gain form the information gathered.
5) The ASC is not in conflict with the violation of privacy VS caregiver ethic, regardless of HIPAA.

Sincerely

Marklin E. Brown

Response:

Thank you for your comments regarding the law SB 1973 (Maddy, 1998), incorporated encoded into the California Health and Safety Code in Sections 128736 and 128737.

During the August 20-October 4, 2004 Public Comment period we were seeking comments directly related to the specific content of the proposed regulations. Your comments are not directly related to the content of the changes to the regulations that OSHPD is proposing. You might be interested, however, in a brief history of the bill.

Senate Bill (SB) 1109, Chapter 543, Statutes of 1995 stated that

> "It is the intent of the Legislature to accomplish all of the following:
>
> (1) Evaluate the data collection programs of OSHPD from a broad perspective to determine their relevance and appropriateness for future use in the changing and increasingly competitive health care marketplace in California.
>
> (2) Involve a broad range of interested parties in the evaluation process, including representatives of the health care industry, providers, consumers, payers, purchasers, and government entities, including the Department of Corporations, the departments that comprise the health and Welfare Agency, and others deemed valuable to the evaluation of the data bases.
>
> (3) maintain and improve the existing financial, utilization, and patient level data collection programs while evaluating future data needs."

Throughout 1996, 1997 and 1998, OSHPD, the required list of interested parties, and others worked in public meetings and hearings to meet the mandates of SB 1109.

SB 1973 was designed to meet the healthcare industry, data users, and the public need for more comprehensive information on the healthcare Californians are receiving. Sections 128736 and 128737 of the California Health and Safety Code mandate that Emergency Department and Ambulatory Surgery data shall be reported to OSHPD.

One comment that OSHPD can address is that “ASC's are not in the business of reporting on their clients. This is a violation of our right to be free of conflicting interests. We are not patient advocates if we must spy on our patients and report their very private data.”

The Patient Data Section of OSHPD has been seeking input, advice and recommendations from several healthcare industry associations since its inception in 1980 including the time during which these regulations were being developed. These organizations include the California Ambulatory Surgery Association, California Health Information Association (including the Ambulatory Information Management subgroup and the Coding and Data Quality Committee), CA Health Policy and Data Advisory Commission (including the Health Data and Public Information Committee and a wide range of represented constituencies), OSHPD's ED and AS Data Consortium (including major stakeholders, reporting entities, information technology experts, vendors, and data users), National Association of Health Data Organizations, several other states' health data agencies, American Health Information Management Association, and the Public Health Data Standards Consortium. Six different surveys were sent to reporting entities (including freestanding licensed ambulatory surgery centers, hospital inpatient medical records, emergency departments, and hospital-based ambulatory surgery centers). Presentations were also made to the Sacramento Health Network, CA Domestic Violence Interagency Committee, CA Department of Health Services, Health Finance Management Association, and Coding Consultants. None of these industry associations raised an issue that reporting data would be a violation of “our right to be free of conflicting interests.”

In response to your comment that “We are not patient advocates if we must spy on our patients and report their very private data.” OSHPD would like to make you aware that (Inpatient) discharge data have been collected and used since 1980. We would like to reassure you that your patient data will be submitted through a secure encrypted connection, that the locations of the Patient Data Section (PDS) staff and the data warehouse are secured, and that a full-time information security officer is employed with OSHPD. All data stored on OSHPD's servers are protected by Oracle advanced security. OSHPD meets and/or exceeds HIPAA security standards despite that fact that we are not a covered entity. OSHPD has been collecting Social Security Numbers (SSN) for over 14 years with no known security breaches. SSNs are encrypted into Record Linkage Numbers (RLN) and are not found on published materials. Data users request patient data for a variety of purposes. Some current uses of inpatient data include injury surveillance and child injury prevention. Facilities also request data for internal quality assurance measuring, product development, and market-share analysis. Future uses of ED and AS data may include emergency medical service planning and analyzing trends in the utilization of Emergency Department

and the Ambulatory Surgery settings. Patient data provide vital information for improving healthcare for Californians.

Any data that is released to the general public is aggregated data. No “very private data will be revealed.” You are encouraged to explore our website and to contact OSHPD’s Health Information Resource Center (HIRC) to view some of our currently available downloadable products.

We hope that this response will allow you to continue to consider yourself and OSHPD patient advocates.

Comments:

>>> "John Zeiter" <> 9/9/2004 3:00:49 PM >>>
This is just one more thing that ultimately leads to the rising costs of healthcare. The man-hours needed to collect and submit this data (in addition to 50 cents per patient) is enormous, not to mention violating privacy rights of the patients and physicians and ASCs. As an owner of a free-standing ASC, and in the face of decreasing reimbursements both on the professional side and the facility side, we certainly cannot afford more extraneous expenses.

In addition, during this Public comment period, you ought to make it easier for people to find your mailbox--i.e. there ought to be something on the Home page of oshpd. I'm sure that if any of the "public" understood this ludicrous data collection initiative, they most certainly oppose it.

John H. Zeiter, M.D.

Response:

Thank you for your comments regarding OSHPD's proposed changes to Patient Data Reporting Requirements (Title 22, Division 7, Chapter 10 - Health Facility Data, Article 8).

Data users request patient data for a variety of purposes. Some current uses of inpatient data include injury surveillance and child injury prevention. Facilities also request data for internal quality assurance measuring, product development, and market-share analysis. Future uses of ED and AS data may include emergency medical service planning and analyzing trends in the utilization of Emergency Department and the Ambulatory Surgery settings. Patient data provide vital information for improving healthcare for Californians.

OSHPD is not violating any privacy rights. The data set does not include any names or addresses. Social Security Numbers are encrypted into a random record linkage number and are not available in publicly available published reports. All data sent to OSHPD is sent over secure lines and is encrypted. Although OSHPD is not a covered entity or required to meet HIPAA standards we strive to be consistent with HIPAA privacy and security requirements. OSHPD employees are also healthcare consumers and therefore share your data privacy concerns. OSHPD has been collecting patient level data for over 20 years and is proud of the security and privacy of its data collection programs.

OSHPD shares your concern regarding the rising cost of health care which is why we have proposed an 837 compatible national standard data set as the basis for the Ambulatory Surgery data set. Facilities are using the national standards for electronically processing health care claims (837 claims transactions). The 837 HCSDRG is compatible with the data content of other

837 Health Care Claim transaction set standards. This should mean that many of the required data elements are already collected by your facility. Also, OSHPD is not requiring the purchase or installation of any new software or hardware by your facility. We have expanded the MIRCal online reporting system that is currently being used to report inpatient data. OSHPD will accept data from any source that meets the MIRCal format and specification requirements. Mapping from claims forms, (chargemaster) billing information, medical records, pre-admissions data or any other pre-entered data-source may be possible and may reduce repeated key or manual entry of data. OSHPD anticipated that the length of time between the passage of the law and the proposed regulations would give facilities time to prepare for the reporting requirements listed in SB 1973 (Maddy, 1998).

The data collection initiative has been supported by members of the public who were sufficiently interested in healthcare data that they joined a variety of formal organizations to ensure that their voices were heard and that they would hear about any such initiatives well before they became proposed regulations. OSHPD received input from California Ambulatory Surgery Association, California Health Information Association (including the Ambulatory Information Management subgroup and the Coding and Data Quality Committee), Ambulatory Surgery software vendors, the California Health Policy and Data Advisory Commission (including the Health Data and Public Information Committee with a wide range of represented constituencies), OSHPD's ED and AS Data Consortium (including major stakeholders such as freestanding clinics to represent reporting entities, information technology experts, vendors, and data users), the National Association of Health Data Organizations, and American Health Information Management Association, to mention some of the supporters.

In September 2003 OSHPD made a presentation at the California Ambulatory Surgery Association's (CASA) Annual Conference that described the ED and AS Data Collection initiative / program. This conference, held in Sacramento, was open to Ambulatory Surgery professionals. Surveys were sent out to freestanding ambulatory surgery centers in November and December of 2003. The first issue of *Quick Notes* was circulated in February of 2004 and was based largely on the results of the surveys that were returned. *Quick Notes* always provides OSHPD contact information and people who contact OSHPD are always given as much information as we have available. *Quick Notes* are e-mailed, hardcopy mailed, and available from our website. OSHPD has made numerous outreach efforts and hopes that ambulatory surgery professionals will explore our website and contact us.

Please note that the expanded MIRCal system will available for submission of data, on a voluntary basis, for the October to December 2004 reporting period. This is an opportunity to "try the system out" and test the mapping of data from various in-house systems. Facilities who voluntarily report will have greater access to limited OSHPD staff resources and will also benefit from being able to

initiate in-house staff learning in the least stressful environment. OSHPD MIRCal analysts will be available for assistance from 8 a.m. to 5 p.m., Monday through Friday, except for Official State Holidays.

Thank you for taking the time to respond to our proposed regulations. OSHPD has proposed the regulations that it feels most accurately implement, interpret, and make specific the provisions of SB 1973 (as they have been written into Sections 128736 and 126737 of the California Health and Safety Code) whilst being least burdensome to most facilities. We appreciate your time and effort and hope that our response will address your concerns.

Comment:

Our software company has told me that until your comment period is closed (Oct. 4th), they will not finalize their report generator. I'm not sure how we will begin to collect data if we are not able to do it on our computer.but that is our problem I suppose. However, they make a valid point, that if this is all a "proposal" on your part until the end of the comment period, how can we be mandated to collect this information before that? Diane Troolin, Roseville Surgery Center

Response:

The format and specifications will continue to be "proposed" until the regulations are adopted. The public comment period concluded October 4, 2004.

The format and specifications included with the posting of the regulations for public comment have been available for review on the MIRCal website located at: http://www.oshpd.ca.gov/hid/MIRCal/new/EDASProposedRegs.pdf.

We do not anticipate any substantive changes to the format and specifications for the collection of ED and AS data.

Comment:

Hello,
The last time I spoke to you, or someone in your office, I was told that the NEW SPECIFICATIONs for reporting were not finalized but would by mid August 04. Can you pls tell me if the specifications for IP, ED, and AS have been finalized - so we may begin programming for our California sites reporting to you.
Many Thanks!! Carol Harrington Meditech

Response:

The format and specifications will continue to be a "DRAFT" version until the regulations are adopted. The public comment period concluded on October 4, 2004.

The format and specifications included with the posting of the regulations for public comment is available for review on the MIRCal website located at: http://www.oshpd.ca.gov/hid/MIRCal/new/EDASProposedRegs.pdf.

We do not anticipate any changes to the format and specifications for the collection of ED and AS data.

Comment:

>>> marks 08/26/04 16:59 >>>

Good afternoon,

I am requesting a copy of the proposed text for Sections 97210 through 97265 (non sequential) regarding "Data Reporting Requirements". This proposed rule has a comment deadline of 10/04/04. If possible, please send by email (as an attachment) to regdb.com. Our contact number is (916) and the fax number is (916) (attn: Mark Seeman). Any help is appreciated. Thank you for your time.

Sincerely,

Mark Seeman

StateNet

Response:

Date: Thu, 26 Aug 2004 17:10:37 -0700
From: Candace Diamond <CDiamond@oshpd.state.ca.us>
To: marks@statenet.com
Subject: Re: Proposed rule text request - "Data Reporting Requirements"

I'll be out of the office until September 20, 2004. For assistance or information now, please call the main Patient Data Section number (916) 323-7679 or contact Rob Fox at rfox@oshpd.ca.gov. Thank you.

Good morning,

I am attaching a copy of the proposed text for Sections 97210 through 97265 regarding "Data Reporting Requirements". This proposed rule has a comment deadline of 10/04/04. It is being sent by email (as an attachment) per your request.

Thank you for your interest.

Irene Ogbonna

Irene J. Ogbonna, AGPA
Healthcare Information Division
Office of Statewide Health Planning and Development

Comment:

>> >>>> "Suzanne Bell" <> 9/9/04 10:20:06 AM >>>

Good Afternoon

I am trying to obtain a copy of the proposed text for the below regulation. Can you email a copy to me or advise me where on the website I can retrieve a copy? I did look on the website but was unable to find it.

Thank you

Suzanne Bell
Netscan iPublishing

Amendments and additions to Article 8-Data Reporting Requirements, to implement the mandated collection and transmission of Emergency Care and Ambulatory Surgery data through the Medical Information Reporting for California (MIRCal) system.

Response:

From: "Rob Fox" <RFox@oshpd.state.ca.us>
To: <"Suzanne Bell">
Cc: "Irene Ogbonna" <IOgbonna@oshpd.state.ca.us>
Sent: Thursday, September 09, 2004 1:43 PM
Subject: Re: Fw: Proposed Text

Ms. Bell,

Attached is a PDF copy of the proposed regulations for Emergency Care and Ambulatory Surgery collection that you requested. I've also included the link to our website where the proposed regulations are located:

http://www.oshpd.ca.gov/hid/MIRCal/new/index.htm

Once you reach this page you will see links for "Proposed Regulations", "Notice", and the "Initial Statement of Reasons". If you wish to comment on the proposed regulations, please keep in mind that the public comment period ends at 5 p.m. October 4, 2004.

If we can be of any further assistance, please contact myself, Candace Diamond (cdiamond@oshpd.ca.gov), or Irene Ogbonna (iogbonna@oshpd.ca.gov).

Rob Fox, SSMI
Patient Data Section
Healthcare Information Division
Office of Statewide Health Planning and Development
818 K Street, Suite 100 (916) 324-2710
Sacramento, CA 95814 FAX (916) 327-1262
E-mail: rfox@oshpd.ca.gov
Web Page: www.oshpd.ca.gov

>> >>>> "Suzanne Bell" <> >>

Thank you very much!